Pediatric Wellness History

greystone CHIROPRACTIC

Date: _____

Name: _____ DOB: _____ Age _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home # _____ Cell # _____

(name/relation) _____ / _____ e-mail: _____

Who can we thank for referring you into our office? _____

I. Health Profile

What brings you into our office today? ***If the child is here for general wellness services, please skip this part and go to Section II below***.

Describe the nature of the problem. Rate Severity (scale 1-10, with 10 being severe, 1 being mild). When and how did this start? Are symptoms constant or intermittent?

_____

_____

_____

Since the problem started it is: ___the same ___getting better ___getting worse

What makes the problem worse? _____

What makes the problem better? _____

Does this interfere with: ____School ____Sleep _____Sports _____ Family ____Other

Have you seen other doctors for this condition? _____ Chiropractor _____ MD _____ Other

Name/Location: _____ Date: _____

What was the recommendation? _____

II. History Have they had any surgeries and/or hospitalizations? ____Yes ___No

If yes briefly explain: _____

_____

Have they ever had any other injuries? ___Yes ___No

If yes, briefly explain: _____

_____

Birth Attendant: □ Home □ Birthing Center □ Hospital □ OBGYN □ Midwife

Complications during pregnancy? ____Yes ____No List:_____

Birth intervention? _____Forceps _____Vacuum _____Caesarian: Planned or Emergency

Formula-fed?_____ How long?_____ Breast-fed?_____How long?_____

Food allergies:_____

Any other things that need to be noted?_____

_____

III. Habits

1. Fast foods regularly? YES NO Which: _____
2. Sweets / refined carbohydrates? YES NO _____
3. How much water does your child drink daily? _____ oz.
4. Are there smokers in your child's home? YES NO
5. Is your child physically active daily? YES NO
6. Been on antibiotics before? YES NO If yes, how many times? ___ Most recent date: _____

IV. Sleep How well does your child sleep? ___Well ___ Trouble falling asleep ___ Trouble staying asleep

Does your child suffer from Insomnia? YES NO Night Terrors? YES NO

What is the average number of hours your child most often sleeps each night? _____

Does the child experience any of the following?

❑ Indigestion	❑ Excessive crying, irritability	❑ Behavioral Issues
❑ Food reactions	❑ Frequent urination	❑ Muscle aches/pains
❑ Constipation	❑ Bedwetting	❑ Excessive fear/worry
❑ Diarrhea	❑ Nervousness	❑ Headaches/migraines
❑ Leg cramps	❑ Concentration issues	❑ Anger/Aggression
❑ ADD/ADHD	❑ Ear Infections	❑ Asthma
❑ Autism/Spectrum	❑ Earaches	❑ Allergies/sinus
❑ Frequently sick	❑ Stomach aches	❑ Overheats easily

HIPPA Agreement

Consent for treatment, payment and healthcare operations

I, _____ (parent or guardian of minor patient) consent to the use of the patient's Protected Health Information (PHI) by Dr. Lee Goldenberg and/or staff of Birmingham Wellness LLC, d/b/a Greystone Chiropractic (hereafter "the practice"), for the purpose of providing treatment for me, for purposes relating to the payment of services rendered to my child/minor in my care, and for the practice's general healthcare operations. Healthcare operations may include, but are not limited to: quality assessment activities, credentialing, business management, or general operational activities.

I understand the practice's diagnosis, treatment plan, and other evaluation and management information may be conditioned upon by consent as evidenced by my signature on this document. For purposes of consent, PHI means any information, including demographic information, created or received by the practice, that relates to the child's past, present or future physical or mental health or condition; the provision of healthcare to him or her; and that either identifies them or from which there is a reasonable basis to believe the information can be used to identify this patient.

I understand that I have the right to request a restriction on the use and disclosure of the PHI for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However if the practice agrees to restriction I request, the restriction is binding on the practice until which time I remove the restriction in writing.

I understand that I have the right to review the practice's notice of privacy practice prior to signing this document. The notice of privacy practices describes the patient's rights and the practice's duties regarding the types of uses and disclosures of their PHI. I have the right to revoke this consent, in writing, at any time, except to the extent that physician or the practice has acted in reliance on this consent.

I understand that I am responsible for the charges incurred at the practice by the aforementioned patient, whether or not an insurance policy covers chiropractic care or office visits. Some policies cover different amounts, and it is my responsibility to know and understand what the insurance coverage offers and what the patient is responsible for.

_____

Guardian Name (print) Guardian Signature Date

Informed Consent & the Doctor-Patient Relationship Patient name:_____

Chiropractic Care

It is the premise of chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis (balance and regulation). This allows the body to establish normal function, express appropriate adaptation as needed, and employ its recuperative, health-sustaining powers. The relationship between the spine and nervous system may affect the conduction of nerve impulses affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment, this allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes, and the physical and spinal conditions of each individual patient.

Chiropractic Analysis

The doctor will conduct a clinical analysis for the express purpose of detecting the presence of vertebral subluxation/s and the effects of those misalignments. If not detected, and the patient is in need of care from another provider, the patient will be informed and referred for other appropriate care.

Clinical Results

The purpose of chiropractic care is to promote health and vitality through the correction of the vertebral subluxation complex. Since there are many variables in healthcare, it is difficult to predict the timing, degree of response to care, and efficacy of chiropractic care for any given patient. However, the doctor may make recommendations for clinical management based on known circumstances and clinical experience. Due to complexities of nature, and the many variables, both known and unknown that can affect patient response to care, no doctor can promise specific results. The doctor of chiropractic (DC) is licensed to provide a specialized, unique, non-duplicating health service. The chiropractor is licensed in a special area of practice and is available to work alongside other providers in your healthcare regimen.

Medical Diagnosis

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the spine and body and their effects on the nervous system, they are not medical doctors, internists, or surgical specialists. Therefore, every patient should be mindful of their own condition/s and should secure other opinions should they have concerns as to the nature of any other symptoms or their total health picture. Your doctor of chiropractic may express an opinion as to whether or not further consult is necessary, but the patient is responsible for the final decision and any subsequent action.

Contraindications to Chiropractic Care

Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes adverse reactions. In rare cases, however, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures, or disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contraindicated. It is the responsibly of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of the doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.

Patient Consent

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care. I have read and understand the Informed Patient Consent and Doctor Patient Relationship. I hereby request and authorize the doctor to render chiropractic evaluation, and care if necessary.

_____

Guardian Name (print) Signature Date