PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: ____/____/____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Name of Parents / Guardians: _____ Work Phone: _____

Referred By: _____

Purpose for contacting us? _____

Other Doctors seen for this condition: ☐ No ☐ Yes If yes, Doctors' names and Prior Treatments: _____

_____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other: _____

Family History: _____

Previous Chiropractic care: ☐ No ☐ Yes Chiropractor name: _____

Date of last visit: ____/____/____ Reason: _____

Name of Pediatrician: _____

Date of last visit: ____/____/____ Reason: _____

Are you satisfied with the care your child has received there? ☐ No ☐ Yes

Number of doses of **Antibiotics** your child has taken:

During the past Six Months: _____ Total during his/her lifetime: _____

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months: _____ Total during his/her lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ☐ No ☐ Yes List: _____

Ultrasounds during pregnancy? ☐ No ☐ Yes Number: _____

Medications during pregnancy / delivery? ☐ No ☐ Yes List: _____

Cigarette / Alcohol use during pregnancy? ☐ No ☐ Yes

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section: Emergency or Planned?

Complications during delivery? ☐ No ☐ Yes List: _____

Genetic Disorders or Disabilities? ☐ No ☐ Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: ☐ No ☐ Yes How long: _____

Formula Fed: ☐ No ☐ Yes How long: _____ Type: _____

Introduced to solids at: _____ months, Cow's Milk at _____ months

Food / Juice Allergies or Intolerance: ☐ No ☐ Yes List: _____

_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound: _____

Respond to Visual Stimuli: _____

Hold Head Up: _____

Sit Up: _____

Cross Crawl: _____

Stand Alone: _____

Walk Alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ☐ No ☐ Yes

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ No ☐ Yes List: _____

_____

Has your child ever been involved in a car accident? ☐ No ☐ Yes List: _____

Has your child been seen on an emergency basis? ☐ No ☐ Yes List: _____

Other traumas not described above? ☐ No ☐ Yes List: _____

Prior surgery? ☐ No ☐ Yes List: _____

Menarche? ☐ No ☐ Yes Age: _____

Childhood Diseases:

Chicken Pox: ☐ No ☐ Yes, Age: _____

Mumps: ☐ No ☐ Yes, Age: _____

Rubella: ☐ No ☐ Yes, Age: _____

Rubeola: ☐ No ☐ Yes, Age: _____

Whooping Cough: ☐ No ☐ Yes, Age: _____

Other: ☐ No ☐ Yes, Age: _____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____

FINANCIAL POLICY AND SERVICE CONTRACT

_____ I understand that Willis Family Chiropractic will bill my insurance as a courtesy, but **my patient portion (co-pays, deductible and coinsurance for procedures) is my responsibility and due at the time of service.** In the event that your staff is unable to determine my responsibility at the time of service, I will be billed and my payment is due within 30 days of that bill. A $5 monthly finance charge will apply for each month beyond the 30 days my account remains outstanding.

_____ I am responsible for knowing my policy guidelines. If payment is denied by my insurance because I did not complete paperwork required or for any other reason, I understand that I am responsible for payment of the balance accrued.

_____ I understand that if Dr. Willis is contracted with my insurance company, you will apply the contracted adjustment to my claims reducing my costs. The exception to this, if applicable, is hormone testing lab fees, in which I agree to pay the full balance owed on the hormone testing charges since the doctor's costs may be greater than the allowed rate.

_____ If I have Medicare, I understand that you will bill Medicare as a courtesy. I also understand that they may not cover services including but not limited to x-rays, exams, therapies and supplements. I agree to pay for these services and for the adjustment services at the time of service and understand that Medicare will reimburse me, the patient, directly the for covered services determined by Medicare.

_____ I authorize Willis Family Chiropractic to release any information to my insurance company, adjuster, attorney, or another practitioner involved in this case.

_____ If my insurance fails to pay my claims in a timely manner, I authorize Dr. Willis to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ I authorize payment be made by my insurance company directly to Dr. Willis, with the exception of Medicare. If my current policy prohibits direct payment to Dr. Willis, I hereby instruct my insurance company to make out the check to me and mail it as follows: *Willis Family Chiropractic, 10451 Garverdale Ct. Suite 201, Boise, ID 83704.* THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. Furthermore, I authorize Dr. Willis to deposit checks received on my account for services rendered if they are made out in my name.

_____ My primary insurance company, _____, is responsible for payment for services at Willis Family Chiropractic.

_____ I do have a secondary policy with _____ insurance company and understand that Dr. Willis will send claims to them for processing.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I am welcome to express all concerns arising out of this financial agreement.

_____	_____	_____
Printed Patient's Name	Patient's Signature	Date

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation and/or adjustments are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent for *Willis Family Chiropractic* to perform chiropractic treatment to my joints and soft tissues. I understand that the procedures may consist of manipulations or adjustments involving movement of the joints and soft tissues. I also consent to the use of physical therapy and nutritional counseling as directed by my chiropractic doctor. In the event that X-rays are needed, I understand that a small dose of radiation is produced to capture an image and therefore consent to the performance of necessary films.

Although spinal manipulation/adjustment is considered to be one of the safest & most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated as follows:

Soreness: I am aware that it is not uncommon to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies generate heat and may rarely cause a burn.

Treatment Results

I appreciate that there are beneficial effects associated with treatment procedures performed at *Willis Family Chiropractic* including decreased pain, improved mobility and function, and reduced muscle spasm. However, I understand there is no certainty that I will achieve these benefits and I acknowledge that no guarantee has been made tome.

Alternative Treatments Available

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Nontreatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.

Signature of patient_____ **Date** _____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individual information.

A. OUR COMMITMENT TO YOUR PRIVACY

- Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Our practice will post a copy of our current Notice in our offices in a visible location at all times. You may request a copy.

B. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. We may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. We may contact your health insurer to certify that you are eligible for benefits and we may provide them with details regarding your treatment and health status. We also may use and disclose your IIHI to obtain payment from third parties or to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or leave a message) to remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement, OR criminal conduct in or out of our office
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or the cause of death.
6. **Organs and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement.
7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. 9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) to the appropriate authorities.
10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law.
11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate.
12. **Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

BY SIGNING BELOW, YOU AGREE TO AND UNDERSTAND THE PREVIOS STATEMENTS CONSERNING YOUR PRIVACY RIGHTS AS A PATIENT.

PATIENT'S SIGNATURE _____ DATE _____