MINDFUL FAMILY CHIRIROPRACTIC

CHILD HISTORY FORM

Please complete this detailed history form and return it to the doctor. Should you require any assistance, please let us know as we will be happy to assist.

Date : _____Child's Name: _____( )M ( )F DOB: _____Age:

Mother: _____Father: _____Legal Guardian:

Best Phone: _____( ) cell ( ) Home **SS NO.** ----------_____

Address: _____City:_____Zip:_____

Email Address:_____@_____.com

Please supply a 4 digit code, you'll easily remember for computer log-in:_____

Who can we thank for referring you? _____

Pediatrician Name:_____Last Appt Date: _____

Siblings? Names/ages: _____

What is your main reason for today's visit? ( ) Wellness Check - ( ) Other:

_____

List any other care your child has undergone with regard to this complaint including medications:

_____

_____

Date of onset (mm/yyyy): _____Onset was: ( ) Sudden ( ) Gradual ( ) Associated with an event

Duration of problem/episode: (Check one)
____( ) Minutes ( ) Hours ( ) Days ( ) Months ( ) Years

Pattern of Problem: (Check one)
( ) Constant ( ) Intermittent ( ) Occasional ( ) Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's Body function and daily abilities_____

_____

Prior occurrence or episodes? _____

Other health concerns? _____

Any known allergies? _____

PID _____

HISTORY OF BIRTH

( ) Hospital ( ) Birthing Center ( ) Home ( ) MD/DO ( ) Midwife

Duration of Pregnancy: ____Weeks **Birth Weight** _____**Birth Length** _____**Hours in labor**:_____
Was the birth assisted? ( ) Yes ( ) No If yes, how? ( ) Forceps ( ) Vacuum extraction ( ) C-Section ( ) Induced Labor
Were medications given to the mother at birth? ( ) Yes ( ) No if yes, what? _____
Was the delivery 'normal'? ( ) yes ( ) no If no, what were the complication_____
Birth Position: ( ) Head first ( ) Breech ( )Other:_____
APGAR at Birth___ /10 & after 5 minutes___ /10 ( ) **UNKNOWN**

GROWTH AND DEVELOPMENT

Was the infant alert & responsive within 12 hours of delivery? ( ) Yes ( ) No If no, explain_____
_____
Are there any apparent delays? _____
Are there any suspected delays? _____
Sleeps on his/her-*choose all that apply*: ( ) Back ( ) Stomach ( ) Right side ( ) Left Side ( ) Both sides ( ) Incline ( )Unknown
Describe any health problems that exist on the mother &/or fathers side of the family? (i.e. cancer, diabetes etc.) _____
Do the child's siblings have any health problems? ( ) Yes ( ) No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

CHEMICAL STRESSORS

During pregnancy, did the mother: 1. Smoke ( ) Yes ( ) No 2. Drink alcohol? ( ) Yes ( ) No
3. Drink caffeine? ( ) Yes ( ) No 4. Take Rx/supplements? ( ) Yes ( ) No If yes, what? _____
5. Become ill? If so, how? _____ 6. Receive ultrasounds? ( ) Yes ( ) No If yes, how many? ____
7. Receive invasive procedures (i.e. amniocentesis, CVS)? ( ) Yes ( ) No 8. Did Mother exercise during pregnancy? ( )No ( ) Yes 9. Was/IS your child breastfed? ( ) No ( ) Yes, for how long? _____

At what age was: Formula introduced? _____Brand? _____
Cows milk?____yrs/mos Solid foods? ____yrs/mos

Did your child receive vaccinations? ( ) Yes ( ) No if yes, which ones? _____
Did your child react to them? ( ) Yes ( ) No
Has your child had antibiotics? ( ) Yes ( ) No If yes, how many & why?_____
Any pets at home? ( ) Yes ( ) No Any smokers at home? ( ) Yes ( ) No Childhood illnesses? ( ) Yes ( ) No

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? ( ) Yes ( ) No Any problems bonding? ( ) Yes ( ) No
Avg # hours of TV/electronics per week ___hrs
Any behavioral concerns? ( ) Yes ( ) No if yes, explain_____
Does your child have difficulties sleeping ( ) Yes ( ) No If yes, explain: _____

TRAUMATIC STRESSORS

Any evidence of trauma during birth? ( ) Bruises ( ) Odd shaped head ( ) Stuck in birth canal ( ) Fast & or excessively long birth ( ) respiratory depression ( ) cord around neck ( ) other _____
Any falls/accidents during pregnancy? ( ) Yes ( ) No Has the child had any major falls since birth ( ) Yes ( ) No If yes, did the child need stitches or obtain a fracture? Describe: _____

Any hospitalization's? ( ) Yes ( ) No Please explain: _____

Is your child involved in any activities (Yoga; Tumbling, etc)? _____# Hrs/week?_____
Age child began _____

Signature of Parent or guardian: _____

PID_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above informed Consent and herby grant permission for my child to receive chiropractic care.

O Please check this box if you would like MINDFUL FAMILY CHIROPRACTIC to provide your pediatrician an overview of todays initial visit. By selecting this option, you give permission for the doctors and staff to communicate about the treatment plan and condition to the provider(s) listed below. This ensures all providers are communicating effectively for the childs care.

Pediatrician Name: _____ Office Location: _____ Phone: _____

Other Provider Name: _____Type of provider: _____
Office Location: _____ Phone: _____

Other Provider Name: _____Type of provider: _____
Office Location: _____ Phone: _____

Dr. Signature _____

MINDFUL FAMILY CHIROPRACTIC

PID_______________

PATENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:___________________________Signature:_________________________________Date:____________________

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine a appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem s remedy the situation promptly.

Thank you for being one of our highly valued patients.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address:_____@_____ **PID** _____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender (circle one):** Male / Female **Preferred Language**:_____

Smoking Status (circle one): Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (circle one): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (ie: 5mg once a day)

Do you have any medication allergies ?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date:_____

FOR OFFICE USE ONLY

Height:_____ Weight:_____ Blood Pressure:_____/_____

Temp:_____ Pulse:_____

Developmental Milestones

Date:_____ PID:_____

Name: _____ DOB:_____ Age:_____ M/F

GROSS MOTOR SKILLS

- ❑ 4 wks Able to hold head up from the table momentarily
- ❑ 3 mths Head and shoulder can be supported by forearms
- ❑ 4 mths Infant can be pulled up into sit position by the hands
- ❑ 6 mths Sits unsupported in the upright position
- ❑ 6 mths Head and shoulders can be supported by the arms
- ❑ 6 mths Rolls from a face down to a face up position
- ❑ 9 mths Crawls
- ❑ 9 mths Stands holding onto furniture
- ❑ 11 mths Walks with someone holding onto one hand
- ❑ 12 mths Walks unassisted
- ❑ 2 years Runs
- ❑ 2 years Negotiates stairs placing 2 feet on each step
- ❑ 3 years Climbs stairs using one foot on each step
- ❑ 4 years Walks downstairs with one foot on each step
- ❑ 4 years Hops on one foot

SOCIAL SKILLS

- ❑ 2 mths Smiles
- ❑ 3 mths Reaches for familiar objects
- ❑ 4 mths Plays with hands
- ❑ 6 mths Plays with feet
- ❑ 9 mths Clearly shows joy and pleasure
- ❑ 12 mths Feeds self with fingers
- ❑ 15 mths Plays peek-a-boo
- ❑ 18 mths Understands yes and no

PARENT SIGNATURE:

_____

FINE MOTOR SKILLS

- ❑ At birth Primitive grasp reflex present
- ❑ 4 mths Holds & shakes a rattle placed in hand
- ❑ 5 mths Grasps objects independently
- ❑ 6 mths Moves an object from 1 hand to other
- ❑ 6 mths Self-feeding, can hold & eat a cookie
- ❑ 6 mths Checks objects by placing them in Mouth
- ❑ 12 mths Picks up object w/ thumb & index Finger
- ❑ 15 mths Turns 2-3 pages of a book at a time
- ❑ 18 mths Turns pages of a book 1 at a time
- ❑ 24 mths Builds a tower containing at least 5 blocks
- ❑ 4 years Builds a tower containing at least 10 blocks

COMMUNICATION SKILLS

- ❑ 7 wks Makes cooing sounds
- ❑ 3 mths Laughs
- ❑ 5 mths Uses one syllable words
- ❑ 8 mths Uses 2 syllable words
- ❑ 12 mths Uses 2 – 3 word vocabulary
- ❑ 24 mths Uses 2 – 3 word phrases

ADAPTIVE SKILLS

- ❑ 10 mnths feeds from a cup unassisted
- ❑ 12 mnths holds own bottle
- ❑ 30 mths feeds self with utensils
- ❑ 30 mths able to identify and match colors
- ❑ 36 mths Copies a circle
- ❑ 42 mths Copies a cross