ONE HEALTH CHIROPRACTIC

Date: _____

PEDIATRIC PATIENT INFORMATION

Patient's Name: _____ Birth Date: _____

Mom's Name: _____ Birth Date: _____

Dad's Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Mom's Phone: _____ Dad's Phone: _____ Email: _____

Patient's Sex: _____ Height: _____ Weight: _____ # of Siblings: _____

How did you hear about us? _____ Hobbies: _____

Has patient ever received Chiropractic care? YES NO - How recently? _____

CURRENT MAIN COMPLAINT/SYMPTOMS

Present/Major Complaint: _____

When did this complaint start? _____

Describe quality of this complaint: ☐ Ache ☐ Burning ☐ Deep ☐ Discomfort ☐ Dull ☐ Intense ☐ Mild ☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Throbbing ☐ Tight ☐ Tingling ☐ Other: _____

Intensity: ☐ 0 (no complaint) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (worst)

Frequency: ☐ Rarely (0-25%) ☐ Occasionally (25-50%) ☐ Frequently (50-75%) ☐ Constantly (75-100%)

Since it started, is this complaint: ☐ Better ☐ Worse ☐ Same

When is the complaint at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Throughout the day

What aggravates this complaint? _____

What relieves this complaint? _____

Has he/she been under medical care/medications for this complaint? ☐ Yes ☐ No _____

Please circle any symptoms that apply to this child currently or in the recent past.

Headaches - Migraine headaches - Dizziness - Fainting - Nervousness - Mental conditions - Sinus problems - Allergies - Head colds - Ear problems - Earaches - Hearing loss - Eczema - Fatigue - Vision problems - Runny nose/congestion - Sore throat - Tonsillitis - Laryngitis - Adenoid problems - Stiff neck - Cough (acute or chronic) - Croup - Insomnia - Thyroid conditions - Goiter - Bursitis - Heart palpitations - Cold hands - Colic -

Arm, wrist/hand/finger numbness, tingling, or pain - Middle back pain - Difficulty breathing - Shortness of breath - Asthma - High blood pressure - Heart Conditions - Chest pains - Poor circulation - Hardening of arteries - Bronchitis - Pleurisy - Pneumonia - Influenza - Gallbladder conditions - Jaundice - Shingles - Liver conditions - Stomach problems - Ulcers - Gastritis - Acid reflux - Heartburn - Diabetes - Kidney problems - Hives - Fevers - Arthritis - Immunocompromised - Skin conditions - Acne/pimples - Rashes - Boils - Chronic tiredness - Rheumatism -

Colitis - Dysentery - Hernias - Gas Pain - Irritable bowel - Menstrual dysfunction - Miscarriages - Incontinence - Bedwetting - Fertility difficulty - Low back pain - Pain or numbness in legs - Sciatica - Swollen ankles - Poor leg circulation - Weak ankles - Cold feet - Appendicitis - Varicose veins - Difficulty breathing - Knee pain -

Constipation - Diarrhea - Bladder problems - Sexual dysfunction - Pelvic floor instability - Lack of spinal curves - Hemorrhoids - Pruritus - Pain at end of spine while sitting -

Additional Health Information

Describe this child's delivery/birth: _____
Describe this child's eating/feeding/appetite: _____
Quality of sleep for child? _____ # of hours? _____
Vaccines: Fully Vaccinated Partially Vaccinated Reduced Schedule No Vaccines
Number of antibiotic doses child has taken in: _____ last 6 months; _____ lifetime
Developmental milestone issues: _____
Has this child ever suffered any childhood diseases? _____
Has this child ever sustained an injury (playing sports, playground, home, etc.) YES NO
If yes, explain: _____
Has this child ever been in an auto accident? Yes NO; If yes, when _____
Surgeries/Hospitalizations: _____
Current Medications: _____
Family Health History: Heart Disease Diabetes Cancer Other _____

PATIENT AUTHORIZATION

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to One Health Chiropractic. I authorize One Health Chiropractic and its staff to examine and treat my condition as the doctors see fit.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. I understand all nutritional, dietary, and health recommendations are not to treat any disease or condition(s) the patient may have but to support the Chiropractic care provided and health of the individual. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and

procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Release

This is to certify that Dr. Chris Schumann &/or Dr. Jessica Schumann &/or whoever he/she may designate as an assistant has my permission to perform an x-ray evaluation. To the best of my knowledge, I am not pregnant and have been advised that x-ray can be hazardous to an unborn child.

Females: Date of last menstrual period: _____

Consent to Care for Minor

I authorize Dr. Chris Schumann &/or Dr. Jessica Schumann &/or whomever he/she may designate as his/her assistant to administer care as he/she deems necessary to my son/daughter.

Insurance/Finance

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Dr. Chris Schumann &/or Dr. Jessica Schumann and their office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Chris Schumann or Dr. Jessica Schumann or their associates will be credited to my account on receipt. The insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for service rendered will be immediately due and payable. Any credit accrued on my account will not be applied until the service is rendered. I understand that all finances in this office pertaining my care or supplement needs here are my full personal responsibility.

I have read and understand the above and I agree to these policies and procedures.

SIGNATURE: _____ Date: _____

Printed Name of Parent/Guardian: _____ Relationship to Minor: _____