PEDIATRIC HISTORY FORM

Dynamic Life Chiropractic

Today's Date _____/_____/_____

Name_____ Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other (please explain) _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other:_____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

If yes, please explain_____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had**:** _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____

Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_____ Mumps_____ Measles_____ Rubella_____

Whooping Cough_____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Sleeping Problems
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Other: _____
- ☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from high chair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "**C**" for child, "**F**" for family member:

- _____ Heart Disease
- _____ Cancer
- _____ Gastrointestinal disease
- _____ Diabetes
- _____ High / Low blood pressure
- _____ Memory/mood disorder
- _____ Stroke
- _____ Asthma
- _____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: _____

_____Pain/Discomfort; explain_____

_____Injury; explain_____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No Yes (Describe):_____
4. Any **medication taken** for this problem? No Yes: _____
5. Have you seen any **other doctors** for this problem? No Yes: _____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

Whom may we thank for referring you to our office today? _____

I understand that I am directly and fully responsible to Dynamic Life Chiropractic for all chiropractic care my child receives.

I hereby authorize Dr. Kristin Gaines-Porlier and whomever she may designate as her assistants to treat my minor child by any means, methods, and/or techniques the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of their care.

_____ _____

Parent's or Legal Guardian's Signature Date

Dynamic Life Chiropractic Office Policy

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up-to-date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all of the benefit for which you are eligible; but financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits for which you are eligible. We will advise you to pay any amount due for the "deductable" or any other "non-covered" charges.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Patients who do not have Chiropractic included in their insurance coverage are expected to make payments at each visit. For your convenience, we accept: personal checks, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days, there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

Consent

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatments, physical examinations, x-ray studies, chiropractic care, or any clinic services that he deems necessary in my case.

I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

Dynamic Life Chiropractic

Notice of Privacy Practice

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law – or as dictated by – our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice please sign the bottom of this page and return to out front desk receptionist.

Permitted Disclosures:

1. Treatment purposes –discussions with other health care providers involved in your care.
2. Inadvertent disclosures-open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private room.
3. For payment purposes- to obtain payment from any insurance co or other available collateral source-OR-
4. To obtain your recent address. In the event you move and do not leave a forwarding address, we may use your emergency contact information in whatever way necessary to locate and collect any outstanding sums you may owe to the practice/doctor.
5. For workers compensation purposes-to process a claim or aid in investigation
6. Emergency-in the event of a medical emergency we may notify a family member
7. For public health and safety-in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
8. To government Agencies or Law Enforcement-to identify or locate a suspect, fugitive, material witness or missing person
9. For military, national security, prisoner, and government benefit purposes
10. Deceased persons-discussion with coroners and medical examiners in the event of a patient's death
11. Telephone calls or email and appointment reminders-we may call your home and leave a message regarding missed appointments or apprize you of changes in practice hours or upcoming events
12. Change of ownership-in the event this practice is sold the new owners would have access to your PHI.

Note: At any time, this office may update the list of your ways your PHI may be used and all updates are deemed retroactive

Your Rights:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To requests mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and to whom we release information
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however, like restrictions, we are not required to agree to them

Complaints:

If you wish to make a formal complaint about how we handle your health information, please contact Dr. Kristin Gaines-Porlier at 636-887-3400. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Bldg Washington DC 20201

I understand that this office reserves the right to amend this notice of privacy at any time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgment that I have received a copy of Dynamic Life Chiropractic Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient:_____ DOB:_____ ACCT #:_____

Patient Signature:_____ Date:_____

Witness: _____ Witness Signature:_____ Date:_____

Is there a person or persons whom you wish to grant permission to access your medical record at our office?

Name:_____

Relationship:_____

Contact Information:_____

Name:_____

Relationship:_____

Contact Information:_____

If you choose **NOT** to grant permission to anyone please initial inside the box. ☐

Signature:_____

Printed Name:_____Date:_____

If at any time you wish to revoke this permission, please notify the office immediately.