

Freedom Chiropractic

Confidential Children's Health Record

Date: _____

Patient Last Name: _____ First Name: _____

Nick Name: _____ Birth Date: _____ Age: _____

Gender: Male/Female Financially Responsible Party: _____

Address: _____ Phone: _____

City: _____ St. _____ Zip: _____ Alt. Phone: _____

Email Address: _____

Emergency Contact Person: _____ Phone: _____

Relationship to child: _____ Referred By: _____

If you have health insurance, please give your current insurance card to the front desk so they can make a copy of the information.

Health Insurance: _____ ID #: _____

Group#: _____ Phone#: _____

Social Security#: _____ Insured Person's Name: _____

Insured Person's Birth Date: _____ Insured Person's Social Security#: _____

Current Health Condition

Check any of the following your child has suffered from in the last 6 months:

Ear Infections Scoliosis Seizures Chronic Colds Headaches Temper

Bed Wetting Asthma/Allergies ADHD Colic Growing Pains

Digestive Problems Back Pain Recurring Fever Tantrums

Car Accident Other: _____

Childhood Diseases: Chicken Pox Rubella Whooping Cough Mumps

Other: _____

Pediatrician: _____ Reason for last visit: _____

Number of Antibiotics your child has taken in the last 6 months: _____

Previous Chiropractic Care: Yes/No Previous Chiroprator: _____

Time under chiropractic care: _____

Total of Antibiotics your child has taken: _____ Complications During Birth? _____

Birth Interventions: Forceps Vacuum Extraction C Section Other: _____

Feeding History: Breast Fed- How Long? _____ Formula- How Long? _____

Food/Drink Allergies or Intolerance? _____

According to the National Safety Council, 50% of children fall head first from a high place within their 1st year of life. Is this true with your child? _____

Other Trauma: _____

Is your child involved in high impact sports? No/Yes- What Events? _____

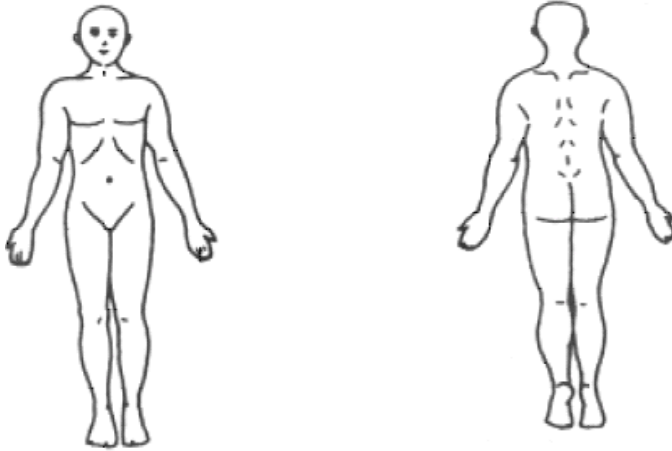
Vaccination History: _____

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Chief Complaint (why your child is here today): _____

When did this condition begin? _____

Please Outline on the Diagram the Area of Discomfort: (if applicable)



Mechanism of Onset:

Before your child began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (Example: fall, auto injury, sports trauma) _____

Symptoms:

When this problem is at its worst, can you explain how your child feels? _____

Does it radiate to other body parts? _____

Timing:

Worse AM Worse PM Worse w/ Activity Intermittent Constant How often do you find your child suffering from this problem? _____

How long does this problem last? (give details of timing) _____

What makes it worse? _____ Better? _____

Medications: What medications is your child currently taking, and for what conditions?

Vitamin, Supplements, or Non-prescription Medicines: _____

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Surgeries/Hospitalizations/Illness:

Type: _____

Date: _____

Type: _____

Date: _____

Type: _____

Date: _____

Please list your child’s daily activities and the length of time they do the activity:

Daily Activities	Less than 1 hr.	More than 1 hr.	More than 2 hrs.	More than 3 hrs.
Homework:				
Athletics:				
Watching TV:				
Sleep:				
Computer Use:				
Backpack Use:				
Household Chores:				
Reading/Concentration:				
Yard work:				

Please list any activities your child experiences difficulty with:

Activity	Painful (can do)	Painful (limits)	Unable to Perform

1. When was your child’s’ most recent auto accident? _____
 - a. Speed: _____
 - b. Front, side, or rear-end collision? _____
 - c. Was treatment received? No/Yes – If yes, where? _____

2. Is there any other injury to your child’s spine, minor or major that the doctor should know about? _____

Family History: Have you or anyone in your child’s IMMEDIATE family had any of the following conditions:

Heart Disease Stroke Diabetes Alzheimer’s Mutiple Sclerosis

Cancer Heart Attack Mental Illness Learning Disability

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High/Low Blood Pressure Arthritis Spine Problems

Epilepsy Anemia Liver Trouble Digestive Problems

Kidney Trouble Chest Pain Asthma

Anything not listed: _____

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CHIROPRACTIC CARE OBJECTIVES

For Patient: _____

When a patient seeks chiropractic health care and we agree to provide care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method by which it will be obtained. This prevents confusion and 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 adjustment of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column that causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

Treatment: We focus on diagnoses and treatment of vertebral subluxation; however, if during the course of a chiropractic 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 another health care provider. Additionally, we do not offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office, and what is available today thanks to progress in spinal health care.

Age: Chiropractic treatment can be successful at any age. The longer the subluxation has been present and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do recommend that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness care: Spinal neglect is so common. It has become an epidemic in our society—despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, _____, have read & 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.

Signature

Date

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I, _____, have read & fully understand the above statements.
(Print name)

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.

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 terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian **Date**

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation.

I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature **Date**

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Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Freedom Chiropractic, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Freedom Chiropractic.

Authorization to Release Medical Record Information:

Freedom Chiropractic is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Freedom Chiropractic. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by Freedom Chiropractic.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Patient or Responsible Party: _____

Date: _____

Signature of Witness: _____

Patient Consent for use of Protected Health Information (PHI)

For Treatment, Payment, & Healthcare Operations (TPO)

I consent to the use and/or disclosure of my (PHI) by Freedom Chiropractic for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting health care operations. I understand that diagnosis or treatment of me by Freedom Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Freedom Chiropractic is not required to agree to the restrictions that I request; however, if Freedom Chiropractic agrees to a restriction that I request, the restriction is binding on Freedom Chiropractic and Kristen C. Kells, D.C.

I have the right to revoke this consent in writing at any time, except to the extent that Kristen C. Kells, D.C. or Freedom Chiropractic has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Freedom Chiropractic's Notice of Patient Privacy Practices prior to signing this document. The Freedom Chiropractic Notice of Patient Privacy Practices has been provided to me. I have read and understand this notice, and have raised any questions regarding the use of my PHI to Freedom Chiropractic's HIPAA Compliance Officer. The Notice of Patient Privacy Practices describes the payment of my bills, or in the performance of health care operations of Freedom Chiropractic. The Notice of Patient Privacy Practices also describes my rights and Freedom Chiropractic's obligations with respect to my PHI.

Freedom Chiropractic reserves the right to amend the Notice of Patient Privacy Practices. I may obtain a revised Notice by calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative Authority