RIVER CITY CHIROPRACTIC PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name_____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ Age: _____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mother's Mobile: _____ Father's Mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

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

CHILD'S CURRENT PROBLEM

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other Please Explain:_____

What is your child's chief complaint(s)? (If applicable)_____

1. When did the problem first begin? Date ____/____/_____ ☐ Gradual ☐ Sudden ☐ Unknown
2. Ever had this problem before? ☐ No ☐ Yes If yes when? _____
3. Have you seen any other doctors for this problem? ☐ No ☐ Yes If yes who? _____When? ____/____/_____
4. What were the results of past treatment? _____
5. On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your child's above complaint(s) by circling the number:

   Primary: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Secondary: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
6. Please list any medication your child is currently taking: _____
7. Has your child sustained any past injuries? (Explain) _____
8. Any past surgeries? (Explain) _____
9. Has your child ever been in an auto accident? ☐ No ☐ Yes if yes; please explain_____
10. Any other problems the doctor should know about? (Explain) _____

PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING FOR YOUR CHILD

___ Headaches	___ Muscle Pain	___ Hypertension	___ Poor Appetite	___Growing Pains
___ Neck Pain/Problems	___ Joint Problems	___ Heart Trouble	___ Bed Wetting	___ Fainting
___ Back Pain/Problems	___ Poor Posture	___ Digestive Disorders	___ Colic	___ Dizziness
___ Orthopedic Problems	___ Scoliosis	___ Stomach Aches	___ Diarrhea	___Seizures/Convulsions
___ Walking Trouble	___ Broken Bones	___ Constipation	___ Anemia	___ Ruptures/Hernia
___ Leg Problems	___ Sinus Trouble	___ Reflux	___Behavioral Problems	___ Sleeping Problems
___ Arm Problems	___ Chronic Earache	___ Asthma	___ ADD/ADHD	___ Colds/Flu

___ Major Falls (Explain) _____ ___ Allergies: _____

INFORMED CONSENT

By my signature below I am acknowledging treatment objectives as well as the risks associated with chiropractic adjustments, therapies, x-rays and all other procedures provided at River City Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of all to the doctor on behalf of my child. After careful consideration, I do hereby consent to a full examination, diagnostic x-rays (if necessary), and treatment by any means, methods, and or techniques the doctor deems for the benefit of my minor child, for whom I have the legal right to select and authorize health care services on behalf of. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

I hereby authorize payment to be made directly to River City Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources on behalf of my child. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to River City Chiropractic for any and all services my child receives at this office.

_____ _____ ☐ Witness Initial

Parent or Legal Guardian's Signature Date

AFFECTS OF DAILY LIVING

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely a part of their life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

RIVER CITY 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 statements below, 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. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas 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 consultation room.
3. For payment purposes: To obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member.
6. 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.
7. To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and text appointment reminders: We may call or text and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. For security of your health information and quality assurance this office is under video surveillance, which may be viewed by office staff, law enforcement, or legal representatives if necessary.
12. Change of ownership: In the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive detailed privacy notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
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.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to copy your xrays onto a CD for personal records there is a $10 administration fee to do so.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Name DOB

_____ _____

Patient Guardian Signature Date

_____ _____

Witness Date