

LAKEWOODS CHIROPRACTIC

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PEDIATRIC HISTORY FORM

Today's Date: ____/____/____

Name: _____ Date of Birth ____/____/____ Social Security # _____

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

Phone (home) _____ Mother Cell: _____ Father Cell _____

Mother: _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City and 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 slept per night? _____ Quality of Sleep?: Good Fair Poor

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

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

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

Has your child ever had any surgeries? Y / N? If yes; please explain _____

Is your child currently on any medications? Y / N? If yes; please list _____

AT WHAT AGE DID THE CHILD:

Respond to sound _____ Follow an object with his/her eyes _____ Hold head 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:

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

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

<input type="checkbox"/> Fall in baby walker	<input type="checkbox"/> Fall from bed or couch	<input type="checkbox"/> Fall off skateboard or skates
<input type="checkbox"/> Fall from crib	<input type="checkbox"/> Fall off swing	<input type="checkbox"/> Fall off bicycle
<input type="checkbox"/> Fall off from high chair	<input type="checkbox"/> Fall off slide	<input type="checkbox"/> Fall down stairs
<input type="checkbox"/> Fall from changing table	<input type="checkbox"/> Fall off monkey bars	<input type="checkbox"/> Other: _____

Has your child ever sustained an injury playing organized sports? Y / N? If yes, please explain

Has your child ever sustained an injury in an auto accident? Y / N? 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:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Memory/mood disorder	<input type="checkbox"/> 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:

- Onset of Problem: Date ____/____/____ Unknown Gradual Sudden
- Ever had** this problem **before**? Yes No If yes, when? _____
- Any **bowel or bladder** problems since this problem began?: Yes No (Describe): _____
- Any **medication taken** for this problem? Yes No If yes, please list: _____
- Have you seen any **other doctors** for this problem? Yes No If yes, please list: _____
- How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

I understand that I am directly and fully responsible to Lakewoods Chiropractic for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are the **sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than 7 years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter.

Client agrees to Maximized Living Health Center does not provide legal services, advice or counsel. Some advice, advertising and materials provided by Maximized Living Health Center may have legal implications. Client agrees to seek independent legal counsel before implementing said advice, advertising and materials. Client agrees to hold Maximized Living Health Center harmless from any legal action taken by others against the client for any Client implementation that caused in whole or in part said legal action. Client assumes all liability and responsibility for client compliance to any State or Federal law, rule or their interpretation thereof by the governing authority.

Printed Name _____

Date _____

Signature _____

NOTICE OF HIPPA PRIVACY PRACTICE

Lakewoods Chiropractic 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 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 our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion 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 consultation room.
3. For payment purposes- to obtain payment from your insurance company or any available 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 to 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-discussions with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders-we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
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 "Detail" 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
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 call Shari Niemcyk at 651-464-0800. If unavailable, you may make an appointment with our receptionist to see her within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

255 Hwy 97 Suite 2A
Forest Lake, MN 55025

Note: 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 have received a copy of Lakewoods Chiropractic Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand 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 Signature) _____ (Date)

_____ (Witness Signature) _____ (Date)