Blue Hills Chiropractic New Patient Form Ages 2-11 Years Old

BLUE HILLS CHIROPRACTIC

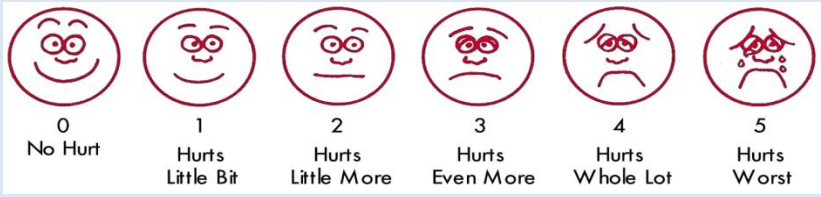
1356 2nd Ave., Cumberland
715.822.2500

11 E Marshall St., Rice Lake
715.475.1700

Child's Name:_____ Date:_____ Referred By:_____
Address:_____ City:_____ State:_____ Zip code:_____
Date of Birth:_____ Age:_____ Gender:_____ Social Security:_____
Mother's Name:_____ Mother's Cell:_____ Work Phone:_____
Father's Name:_____ Father's Cell:_____ Work Phone:_____
List Ages of Other Children in Family:
Pediatrician's Name:_____ Clinic Name:_____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here? Y N
Primary Insurance:_____ Policy #:_____
Policy Holder's Name:_____ Policy Holder's Birth Date:_____
Policy Holder's Employer:_____

History of Present Illness

Is your visit for wellness care? Y N
Specific Concern:_____
When did this begin?_____ How did it originally occur?_____
Is the concern: Getting Better_____ Same_____ Getting Worse_____
If able, describe the concern: Sharp____ Dull____ Numb____ Tingling____ Achy____ Other:_____
Is this concern: Constant____ Frequent____ Intermediate____ Occasional____
Does anything relieve the problem? Y N If yes, what?_____
Does anything make it worse? Y N If yes, what?_____
Previous doctors & treatments:_____
Please rate the pain of the problem if relevant,



Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

____Measles, Mumps	____Headaches	____Stomach Aches
____Chicken Pox	____Dizziness	____Reflux
____Eczema/Skin problems	____Fainting	____Diabetes
____Pneumonia	____Seizures/Convulsions	____Hypertension
____Asthma/Wheezing	____Heart Trouble	____Anemia
____Cancer	____Orthopedic Problems	____Bed Wetting
____Hepatitis	____Neck Problems	____Behavioral Problems
____Allergies	____Joint Problems	____ADD/ADHD
____Frequent Colds/Sore throat	____Scoliosis	____Ruptures/Hernia
____Diarrhea	____Back Pain	____Growing Pains
____Constipation	____Poor Appetite	____Sleep Problems
____Ear Infections	____Digestive Disorder	____Speech Problems

Please list any medications or supplements your child is currently on: _____

Number of doses of antibiotics your child has taken in his/her history: _____

Has your child ever suffered the following spinal traumas?

____Been in car accident	____Fall from bed or couch	____Fall off skateboard or skates
____Broken bones	____Fall off swing	____Fall off bicycle
____Concussion	____Fall off slide	____Fall down stairs
____Sports Injuries	____Fall off monkey bars	____Other: _____

Date of last visit to pediatrician: _____ Purpose of visit: _____

Y N Has your child ever been treated on an emergency basis? _____

_____

Y N Did you choose to vaccinate your child? If yes, which vaccines? _____

_____

Please list any hospitalizations, surgeries, or traumas: _____

_____

Lifestyle & Diet

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours of sleep do you get each night? _____

Do any of your friends or family smoke? _____

Do you feel stressed out? _____

What was the date of the last eye exam? _____

Do you have trouble paying attention in school? _____

Please give examples of a typical breakfast: _____

Please give examples of a typical lunch: _____

Please give examples of a typical dinner: _____

How many glasses of water a day do you consume? _____

How many servings of dairy do you eat/drink a day? _____

What kind of snacks do you usually eat? _____

What is your favorite food? _____

How many sodas or coffee do you drink each day? _____

How often do you eat fast food? _____

Has your child ever been adjusted before? _____

Do you have any other concerns you want to discuss? _____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Child's Name: _____

Guardian Signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June, 1993) Estimate that incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort. Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment testing and evaluation are performed carefully to minimize risk. Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Child's Name: _____

Guardian Signature: _____ **Date:** _____

Authorization & Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information: _____

Child's Name: _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

-You may request restrictions on your disclosures.
-You may inspect and receive copies of your records within 30 days with a request
-You may request to view changes to your records
-In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
-Obtain payment from third party payers
-Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand the Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request in writing, that you restrict how my personal information is used and or disclosed.

Printed Child's Name: _____

Patient/Guardian Signature _____ Date: _____