CONFIDENTIAL PEDIATRIC HEALTH RECORD

Today's Date: _____ Email Address: _____

Child's Name: _____Middle: _____ Last: _____

Child's Date of Birth: _____ Age: (years) _____ (months) _____ Sex: **M F**

Parent/Guardian Names: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D**

Social Security Number: _____

Your Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of Significant Other: _____ Significant Other Date of Birth: _____

Number of Children: _____Names of Children: _____

Name of Family Doctor: _____ Doctor Phone: _____

Were you referred by another health care professional? **Yes No** Whom? _____

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

Have you ever received chiropractic care? **Yes No** Date of last visit: _____

Has your child ever received chiropractic care? **Yes No** Date of last visit: _____

Name of previous Chiropractor: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CURRENT HEALTH CONDITION:

Describe the major complaint(s)/reason(s) that brings you and your child to our office: _____

_____

_____

When did this start? _____ Has he/she had this before? **Y N**

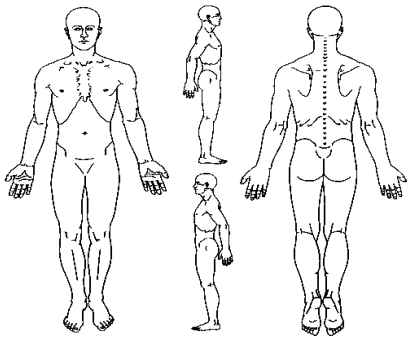
What do you feel caused this problem? _____

Type: **Pain Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling Weakness**

Quality: **Sharp Dull Aching Throbbing Crushing Stabbing Local Radiating Burning Migraine Tension Hormonal Sinus Organic**

On a scale of 1-10 circle the number that represents the severity of your pain:	
NO PAIN	**0**
MILD PAIN	**1 2 3**
MODERATE PAIN	**4 5 6**
SEVERE PAIN	**7 8 9**
DISABLING PAIN	**10**

Indicate where your pain is located with an "X":



Is the Pain: **Constant Frequent Intermittent Occasional Infrequent**

Is this condition due to an accident? **Yes No**

Explain accident: _____

_____

_____

Circle the activities/movements below that are painful for your child to perform?

Sitting Standing Walking Bending Lying Down Other: _____

What activities make your child's condition/pain better? _____

_____

Is this condition worse during certain times of the day? **Yes No** When? _____

Is this condition interfering with **Activities Sleep Routine Other:** _____

Is this condition getting progressively worse? **Yes No**

Has your child seen anyone else for this? **Yes No** Who? _____

Explain previous and current care for this problem: _____

_____

_____

Is your child taking any medications for this problem? **Yes No** _____

_____

LABOR AND DELIVERY HISTORY:

Most people experience their first subluxation (nerve system interference) during the birth process, how do you recall the child's birth?

- ☐ **Vaginal Delivery**
- ☐ **Planned C-Section**
- ☐ **Emergency C-Section**
- ☐ **Hospital Birth**
- ☐ **Home Birth**
- ☐ **Midwife Assisted**
- ☐ **Birth Center**
- ☐ **Birth Induced (Pitocin)**
- ☐ **Forceps Delivery**
- ☐ **Vacuum Extraction**
- ☐ **Anesthesia Administered**
- ☐ **Fetal Distress**
- ☐ **Meconium Staining**
- ☐ **Head Presentation**
- ☐ **Face Presentation**
- ☐ **Breech Presentation**

Birth details: _____

_____

Were there any pregnancy problems? _____

_____

Labor or delivery problems? _____

_____

Congenital defects or anomalies? _____

_____

PAST MEDICAL HISTORY:

Has this child had any surgeries? **Yes** **No** If yes, please explain: _____

_____

Does this child currently take any medications? **Yes** **No** If yes, please list: _____

_____

Has this child suffered any severe accidents? **Yes** **No** If yes, please explain: _____

_____

Pediatrician/Family MD's Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Office Phone: _____

PAST HEALTH HISTORY:

For the following conditions, please circle **O** for previously had or **Δ** for currently have…

O Δ Headaches
O Δ High Blood Pressure
O Δ Low Blood Pressure
O Δ Back Pain
O Δ Diarrhea
O Δ Arthritis
O Δ Fatigue
O Δ Depression
O Δ Broken Bones
O Δ Abnormal Sugar Levels
O Δ Orthopedic Problems
O Δ Rheumatic Fever
O Δ Convulsions/Seizures
O Δ Sinus Troubles
O Δ Decreased Energy
O Δ Attention Problems
O Δ Growing Pains
O Δ Colds/Flu
O Δ Neck Pain
O Δ Sleeping Problems
O Δ Hyperactivity
O Δ Leg Problems
O Δ Joint Problems
O Δ Digestion Problems
O Δ Constipation
O Δ Decreased Energy
O Δ Poor Appetite
O Δ Ruptures/Hernias
O Δ Behavioral Problems
O Δ Coordination Problems
O Δ Walking Problems
O Δ Other:_____
O Δ Fainting
O Δ Dizziness
O Δ Heart Problems
O Δ Arm Problems
O Δ Allergies
O Δ Muscle Jerking
O Δ Irritability
O Δ Anemia
O Δ Earaches
O Δ Paralysis
O Δ Tension
O Δ Stiff Neck
O Δ Bed Wetting
O Δ Asthma
O Δ Neuritis

FAMILY HEALTH HISTORY:

Does any member of your family suffer from your current condition? **Yes No** Whom? _____

Any other pertinent family history/conditions: _____

Is there a family history of: **Heart Disease Cancer Arthritis Diabetes Other:**_____

Is there anything else we should know about your child? **Yes No** _____

_____

Parent/Guardian Signature: _____ **Date:** _____

Patient ID: _____

PAYMENT INFORMATION RECORD

Patient Name: _____

Date of Birth (M/D/Y): _____Social Security Number: _____

Please check one:

[ ] Yes, I have insurance that I would like verified. I am providing Focused on You Chiropractic with my insurance information.

[ ] No, I do not have any insurance that I would like verified.

Subscriber's First Name: _____ Last Name: _____

Subscriber's Date of Birth (M/D/Y): _____Social Security Number: _____

Subscriber's Employer: _____Occupation: _____

Work Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Insurance Co: _____ Phone Number: _____

Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Secondary Insurance Co: _____ Phone Number: _____
Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance companies listed above and assign directly to **Focused On You Chiropractic L.L.P.C** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the **Focused On You Chiropractic L.L.P.C** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

Focused On You Chiropractic – Office Procedures & Policies

The purpose of this form is to allow us to more completely serve you so you can get the best results in the shortest amount of time.

□ UPON ARRIVAL

When you arrive, we ask that you turn off all pagers and/or cell phones and leave food or drinks in your vehicles. This will assist us in maintaining a clean, convenient healing atmosphere. Please complete your daily health form, sign and date it. This will give us a detailed record of how you feel your care is progressing. In order to provide the chiropractic care you need as conveniently as possible and with little interruption, please remove all earrings and necklaces, ensure all jackets, coats, and school bags are removed and left in the waiting area on each visit. There are wall hooks that you may hang your items on. If you have any small items, please feel free to use the white trays located at the front desk. For patients who wear glasses, please remove them before lying face down.

□ ADJUSTING AND CHECKING AREAS

Out of respect for each and every one of our patients, you will be informed when it is your turn to be adjusted. You may then walk back to the adjusting room. Make sure the head rest paper has been changed and then lie face down on the table. The reason we request you to lie down is to relax your muscles prior to your adjustment. Please limit all conversations in these areas to your care.

□ YOUR APPOINTMENTS

The doctor will let you know when he/she needs to see you next. We set aside a time slot where we can be with you 100%. This is your time. If you must reschedule an appointment, please notify the office 24 hours prior to the change. All appointments must be made up as soon as possible in the week for which the change occurred. The appointment cannot be skipped because keeping to your schedule is a critical component in your care. We recognize that emergencies can arise. If you are unable to make it on time, please call to give notice. We will fit you in. A $35 fee for missed appointments with failure to notify the office 24 hours prior will be charged to the patient's account.

□ YOUR HEALTH

Spinal healing and correction takes time. If at any stage in your care you do not feel that you are responding as well as you expected, please discuss your concerns with our office immediately. We will schedule a special time for you with the doctor to discuss your concerns. We want you to get the most from your chiropractic care. Remember it is not how you are feeling, but it is how you are healing.

□ OFFICE HOURS

Monday, Wednesday, Friday are as follows: 8am-10:15am/3pm-5:45pm; Tuesday is by appointment only. If you have a re-exam on Tuesday and miss the appointment or fail to cancel within 24 hours there will be a charge of $45 for the missed appointment. Any other appointments outside of our office hours are up to the doctor's discretion.

□ FINANCES

Payment is due at the time of service, unless other arrangements have been made prior to care. There will be a $25 service charge for all NSF checks. Any balances 60 days passed due without prior arrangements may be referred to collections and will be assessed a 35% service fee. I authorize Focused On You Chiropractic, its agents, representatives, and attorneys (including collection agencies) to contact you via current and future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account. I authorize the use of automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and e-mails, in efforts to contact me in purpose of collecting a portion of the past due account.

□ CHIROPRACTIC QUALITY

The doctors are periodically out of the office to attend seminars and conferences to further their education and the quality of chiropractic care they can bring to their patients. We will build your schedule around those times. Increasing visit frequency before and/or after the scheduling change will make up for patient and/or doctor absenteeism.

I have read and understand as well as agree to these policies.

Patient Signature _____Date _____

HIPPA Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Dr. Gerard Liboiron, D.C.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

I have read the HIPAA Patient Consent Form. All questions I have regarding this policy have been answered.

Patient Signature _____Date _____

Pregnancy Release: Informed Consent to X-ray

To be completed on day of x-ray, if x-rays are to be taken.

All women of childbearing age must sign this release and check the appropriate category.

"This is to certify that, to the best of my knowledge, I am not pregnant. The images radiology consultant and/or doctor has my permission to take x-rays. I will assume all responsibility for all effect on a fetus potentially present."

[ ] I am presently using birth control pill, contraceptive, or an IUD as a form of birth control

[ ] I have started my menstrual period in the last 10 days
Date: _____

[ ] I have had a hysterectomy or tubal ligation

[ ] I am presently in menopause or post-menopause

[ ] Other
Please Explain: _____

[ ] None of the above

Patient Name: _____

Signed: _____

Date: _____

Witness Name (if applicable): _____

Signed: _____

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic at Focused On You Chiropractic or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor Focused On You Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic at Focused On You Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____
Signature of Patient or Guardian:_____
Date:_____

Printed Name of Guardian and Relationship:_____