

Pediatric Health Record

ABOUT THE CHILD

NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:		
DATE OF BIRTH:	AGE:	
SOCIAL SECURITY NUMBER:		
GENDER:	HEIGHT:	WEIGHT:

CHIROPRACTIC EXPERIENCE

HOW DID YOU HEAR ABOUT OUR OFFICE? <input type="checkbox"/> FRIEND/FAMILY <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT NAME: _____ <input type="checkbox"/> INTERNET <input type="checkbox"/> INSURANCE LIST <input type="checkbox"/> OTHER
HAS THE CHILD BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

ABOUT THE PARENT(S)

PARENT(S)/LEGAL GUARDIAN NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH:	

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> CONDITION <input type="checkbox"/> ACCIDENT IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COMES AND GOES
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SCHOOL <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

VACCINATIONS/MEDICATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATION & FREQUENCY OF USE:

MIKULA CHIROPRACTIC, P.C.

4029 Plainfield Ave. NE
Grand Rapids, MI 49525

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:
 DRUGS/MEDICATIONS TOBACCO/ALCOHOL
 IF YES, PLEASE EXPLAIN:

LOCATION OF BIRTH:
 HOME BIRTHING CENTER HOSPITAL

DESCRIBE YOUR DELIVERY:
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY
 PLEASE EXPLAIN:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?
 YES NO
 PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC ILLNESSES OR DISABILITIES:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN _____/10 AT 5 MIN _____/10

ULTRASOUND DURING PREGNANCY? YES NO NUMBER: _____

DID YOU BREASTFEED THE BABY? YES NO
 IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY? YES NO
 IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:
 SOLIDS:

COW'S MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?
 YES NO

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO
 PLEASE EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).
 WAS THIS THE CASE FOR YOUR CHILD? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
 YES NO
 PLEASE EXPLAIN:

AWARENESS OF CHIROPRACTIC PRINCIPLES

WERE YOU AWARE THAT

*DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? YES NO

*THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? YES NO

*CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? YES NO

*IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? YES NO

CHILD'S HEALTH HISTORY

INSTRUCTIONS: Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FREQUENT COLDS, COUGHS,
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> DIFFICULT WEIGHT GAIN	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> COLIC	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DIFFICULTIES

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the methods that will be used to attain it. This will prevent confusion, misunderstanding or disappointment.

Subluxations are interferences to the normal flow of mental impulses traveling over the nerve pathways. It is a chiropractor's goal to locate, analyze, and correct those spinal subluxations so that proper nerve function is returned to the body.

The method of correction is by specific adjustments of the spine. These adjustments are intended to reduce subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair, leading to better health. In some patients, this happens quickly; in others, more slowly. In some patients, the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other than spinal subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease, the chiropractor is not offering to heal, treat, or cure it. Our goal is to allow the body to do the best that it can without nerve interference.

The chiropractic examination and adjustment are not substitute for other types of health care, just as other types of care do not take the place of chiropractic. Being free of subluxation is complimentary to any procedure that is life-enhancing.

I, _____, have read the above, understand it fully and undertake chiropractic care on this basis.

Signature

Date

COMPLETE IF PATIENT IS A MINOR CHILD:

Print Child's Name

I, _____, being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date

AUTHORIZATIONS

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt.

Patient's Name (print)

Date

Signature Authorizing Care (or Parent/Guardian's Signature)

Date

Who should receive bills for payment on your account?

Patient Spouse Parent Worker's Comp Auto Insurance Medicare Health Insurance

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray originals will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office. Upon my signature, x-rays may be released to another provider for a loan period of up to ten business days.

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 situations 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 it's 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 your 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.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____