CARBONE
CHIROPRACTIC
CENTER, LLC

Pediatric History Form
Age 17 and under

WHY THIS FORM IS IMPORTANT
As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of continued wellness care. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

NEW PATIENT REGISTRATION FORM

TODAY'S DATE:_____

PATIENT NAME:_____ NICKNAME:_____ SEX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME ( )_____ CELL: ( ) _____

BEST NUMBER TO REACH YOU?_____ WOULD YOU LIKE APPT REMINDERS TO YOUR CELL? _____

IF YES, WHAT IS YOUR CELL PHONE PROVIDER/CARRIER (VERIZON, AT&T, SPRINT) _____

EMAIL ADDRESS_____ (USED FOR HEALTH NEWSLETTERS AND REMINDERS)

BIRTHDAY:_____ AGE:_____

MOTHER'S/GUARDIAN'S NAME:_____ FATHER'S/GUARDIAN'S NAME:_____

PEDIATRICIAN/FAMILY PHYSICIAN M.D._____ DATE OF LAST VISIT:_____

IS THE REASON YOU ARE HERE TODAY DUE TO AN AUTO ACCIDENT OR WORKER'S COMP?_____
IF SO, PLEASE TELL OUR FRONT DESK, AS THERE MAY BE OTHER FORMS TO FILL OUT.

COMPLAINT/SYMPTOMS INFORMATION

PURPOSE FOR CONTACTING US? _____

HAVE OTHER DOCTORS BEEN SEEN FOR THIS CONDITION? ____NO ____ YES
IF YES, PLEASE LIST DOCTORS AND TREATMENTS

1. _____
2. _____
3. _____

HOW DID THIS HAPPEN? _____

WHEN DID THE SYMPTOMS FIRST START?_____

HOW FREQUENT ARE THE SYMPTOMS?_____

DESCRIBE THE SYMPTOMS:_____

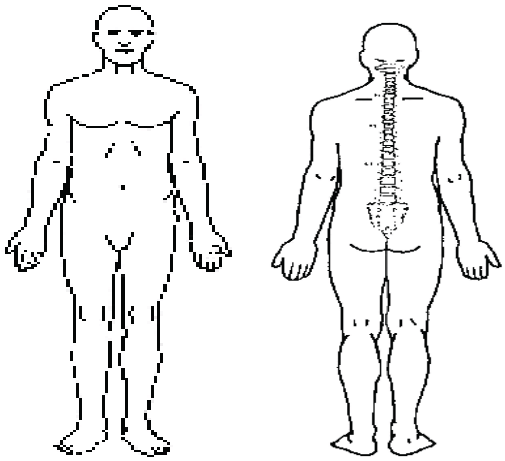
WHAT MAKES IT WORSE?_____

WHAT MAKES IT BETTER?_____

DOES IT RADIATE TO ANY OTHER PARTS OF THE BODY?_____

HAS THIS CHANGED ACTIVITIES AT HOME?_____

PLEASE MARK ALL AREAS OF COMPLAINT ON THE FIGURES BELOW:



PRENATAL HISTORY

MOM'S HEALTH DURING PREGNACY:_____

COMPLICATIONS DURING PREGNANCY: NO YES; IF YES, PLEASE LIST:_____

TYPE OF BIRTH: _____ VAGINAL _____CAESARIAN- EMERGENCY / PLANNED?

LOCATION OF BIRTH: _____HOME _____HOSPITAL _____ BIRTH CENTER

DELIVERED BY: _____ OBSTETRICIAN _____MIDWIFE OTHER:_____

DELIVERY: _____ <36 WEEKS _____ 37-42 WEEKS _____ >42 WEEKS

MEDICATIONS DURING DELIVERY: INDUCTION _____YES _____NO; EPIDURAL _____YES _____NO OTHER:_____

BIRTH INTERVENTIONS: _____FORCEPS _____VACUUM EXTRACTION

COMPLICATIONS DURING DELIVERY: _____NO _____YES; PLEASE LIST:_____

BIRTH WEIGHT: _____ LENGTH:_____

FEEDING HISTORY

BREAST FED: _____YES _____NO; HOW LONG?_____

FORMULA FED: _____YES _____NO; HOW LONG?_____

INTRODUCED TO SOLIDS AT:_____ MONTHS ; COW'S MILK AT:_____ MONTHS

HEALTH HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM:

- ☐ EAR INFECTIONS
- ☐ ASTHMA/ALLERGIES
- ☐ COLIC
- ☐ SCOLIOSIS
- ☐ DIGESTIVE PROBLEMS
- ☐ BED WETTING
- ☐ SEIZURES
- ☐ ADHD
- ☐ CAR ACCIDENT
- ☐ CHRONIC COLDS
- ☐ RECURRING FEVERS
- ☐ HEADACHES
- ☐ GROWING PAINS
- ☐ NECK PAIN
- ☐ BACK PAIN
- ☐ SLEEPLESSNESS
- ☐ OTHER: _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? _____YES _____NO IF YES, WHY?_____

_____

HAS YOUR CHILD EVER HAD ANY SIGNIFICANT INJURIES?_____

PLEASE LIST ANY MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER) YOUR CHILD IS CURRENTLY TAKING AND WHY:

1_____ 5_____

2_____ 6_____

3_____ 7_____

4_____ 8_____

HAS YOUR CHILD TAKEN ANY ANTIBIOTICS? _____NO _____YES
IF YES, HOW MANY DOSES IN LAST 6MO? _____ TOTAL DURING HIS/HER LIFETIME:_____

HAS YOUR CHILD BEEN VACCINATED? _____NO _____YES WHEN:_____

HAS YOUR CHILD EXPERIENCED ANY ADVERSE REACTIONS TO THE VACCINATIONS: _____NO ____YES
IF YES, PLEASE EXPLAIN:_____

ANY CHILDHOOD DISEASES?

☐CHICKEN POX ☐WHOOPING COUGH ☐RSV
☐RUBELLA ☐ MUMPS ☐OTHER: _____
☐MEASLES ☐PERTUSSES

HABITS

DOES YOUR CHILD TAKE A MULTIVITAMIN? _____NO _____YES IF YES, WHAT KIND_____

DOES YOUR CHILD TAKE ANY NUTRITIONAL SUPPLEMENTS? _____NO _____YES IF YES, WHAT KIND_____

HOW MANY SERVINGS OF FRUITS DOES YOUR CHILD EAT ON A DAILY BASIS:_____

HOW MANY SERVINGS OF VEGETABLES DOES YOUR CHILD EAT ON A DAILY BASIS:_____

HOW MANY SOFT DRINKS DOES YOUR CHILD DRINK PER DAY?_____

HOW MUCH WATER (OZ OR CUPS) PER DAY?_____

WHAT POSITION DOES YOUR CHILD SLEEP IN? BACK SIDE STOMACH

HOW MANY PILLOW DOES YOUR CHILD USE?_____

DAILY ACTIVITIES/SPORTS

IS YOUR CHILD INVOLVED IN A SPORTS PROGRAM? _____NO _____YES IF YES, WHAT SPORTS_____

PLEASE LIST ANY INJURIES AS A RESULT OF THEIR
ACTIVITIES:_____

_____

ADDITIONAL INFORMAION

DOES YOUR HAVE, OR EVER HAD, ANY DISEASES OR MEDICAL PROBLEMS NOT LISTED? _____YES _____NO
IF SO, PLEASE LIST_____

DO YOUR HAVE ANY ALLERGIES? _____YES _____ NO
IF YES, PLEASE LIST _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT BEFORE BEGINNING CARE AT CARBONE CHIROPRACTIC CENTER?_____

_____

SIGNATURE_____ DATE_____

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Carbone Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this office of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you are responsible to know when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Carbone Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

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 Care in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Carbone Chiropractic Center to care for my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____and whomever he may designate as assistance to administer chiropractic care as he deems necessary to my _____(indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____

Signature of Staff: _____ Date: _____

HIPPA RELEASE FORM

I have read and understand all information regarding:

1. Patient Authorization regarding the privacy notice.
2. Patient Authorization for appointment reminders/scheduling related matters.
3. Patient Authorization regarding chiropractic care being provided in an open adjusting environment.
4. Patient Authorization for contact regarding chiropractic care, related health services and/or related health products.

Your signature indicates your authorization of these activities.

_____ _____ _____

Name Printed Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

PATIENT INFORMATION RELASE AUTHORIZATION

I, _____, hereby authorization Carbone Chiropractic, to release information contained in my patient records to the individual(s) and only under the conditions listed below:

1. Name of person(s) to whom information can be disclosed to:

_____

_____

_____

2. Specific type of information to be disclosed:

_____

_____

_____

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

_____ _____

Patient's Signature Witnessed By

_____ _____

Date Signed Date Witnessed

_____ _____

Signature of Parent or Guardian Date Signed