PEDIATRIC HISTORY FORM

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1. Today's Date: HR#:

2. PATIENT DEMOGRAPHICS

Child's Name: Birthdate: Gender: ○ M ○ F

Birth Height: Birth Weight: Current Height: Current Weight:

Address: Apt./Unit #: City: State: Zip Code:

Mother's Name: Birthdate:

Mother's Phone: Home: Work: Mobile:

Father's Name: Birthdate:

Father's Phone: Home: Work: Mobile:

Pediatrician/Family MD: City, State:

Last Visit Date: Reason for visit:

CHILD'S CURRENT PROBLEM

3. Purpose of this visit:

○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain:

4. If your child is experiencing pain/discomfort, please identify where and for how long:

5. When did the problem first begin? ○ Unknown ○ Gradual ○ Sudden

Has this problem occurred before? ○ Yes ○ No

If yes, when:

Any bowel or bladder problems since this problem began? ○ Yes ○ No

If yes, describe:

Have you seen any other doctors for this problem? ○ Yes ○ No

If yes, whom?

How long ago? Days: Weeks: Months: Years:

What were the results of past treatment?

How is this problem NOW?
○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off

6. Please list any medication(s) taken for this problem:

7. Has your child ever sustained an injury playing organized sports?

○ Yes
○ No

If yes, please explain:

8. Has your child ever sustained an injury in an auto accident?

○ Yes
○ No

If yes, please explain:

9. HAS YOUR CHILD EVER SUFFERED FROM: Check all that apply.

- ☐ Headaches
- ☐ Seizures/Convulsions
- ☐ Sinus Trouble
- ☐ Fall in baby walker
- ☐ Orthopedic Problems
- ☐ Leg Problems
- ☐ Poor Posture
- ☐ Fall from bed or couch
- ☐ Digestive Disorders
- ☐ Reflux
- ☐ Hypertension
- ☐ Fall from crib
- ☐ Behavioral Problems
- ☐ Muscle Pain
- ☐ Walking Trouble
- ☐ Fall down stairs
- ☐ Dizziness
- ☐ Heart Trouble
- ☐ Scoliosis
- ☐ Fall off bicycle
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Anemia
- ☐ Fall from high chair
- ☐ Poor Appetite
- ☐ Constipation
- ☐ Colds/Flu
- ☐ Fall off slide
- ☐ ADD/ADHD
- ☐ Growing Pains
- ☐ Sleeping Problems
- ☐ Allergies
- ☐ Fainting
- ☐ Chronic Earaches
- ☐ Bed Wetting
- ☐ Fall from changing table
- ☐ Arm Problems
- ☐ Backaches
- ☐ Colic
- ☐ Fall off monkey bars
- ☐ Stomach Aches
- ☐ Diarrhea
- ☐ Broken Bones
- ☐ Fall off skateboard/skates
- ☐ Ruptures/Hernia
- ☐ Growing Pains
- ☐ Fall off swing
- ☐ Other

If other, specify:

_____

10. If you checked allergies, please specify:

_____

_____

_____

_____

I understand that I am directly and fully responsible to Inspire Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

_____ _____

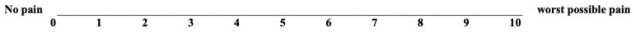
Signature Date

Doctor's Signature

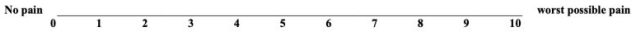
Signature Date

11. Patient Name: Date of Birth:

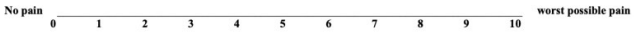
12. 1 – What is your pain RIGHT NOW? If not a pain based complaint, circle 0.



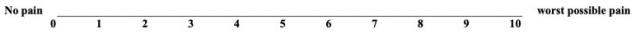
13. 2 – What is your TYPICAL or AVERAGE pain? If not a pain based complaint, circle 0.



14. 3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)? If not a pain based complaint, circle 0.



15. 4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)? If not a pain based complaint, circle 0.



16. OTHER COMMENTS:

Examiner Signature

Signature Date

17. Patient's Name: HR #: Date:

ACTIVITIES OF LIFE

18. Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Carry Children/Groceries				
Sit to Stand				
Climb Stairs				
Pet Care				
Extended Computer Use				
Lift Children/Groceries				
Read/Concentrate				
Getting Dressed				
Shaving				
Sexual Activities				
Sleep				
Static Sitting				
Static Standing				
Yard work				
Walking				
Washing/Bathing				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Driving				
Other				

If other, specify:

19. List Prescription & Non-Prescription drugs you take:

	Medication Name	Dosage	Frequency	Reason for Use
1				
2				
3				

If other, specify:

Patient or Authorized Person's Signature

Signature Date

Doctor's Signature

Signature Date

REVIEW OF SYSTEMS

20.

	Past	Currently	Never
Headache			
Neck Pain			
Jaw Pain, TMJ			
Shoulder Pain			
Upper Back Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Back Curvature			
Scoliosis			
Numb/Tingling arms, hands, fingers			
Numb/Tingling legs, feet, toes			
Pregnant (Now)			
Frequent Colds/Flu			
Convulsions/Epilepsy			
Tremors			
Chest Pain			
Pain w/Cough/Sneeze			
Foot or Knee Problems _			
Sinus/Drainage Problem			
Swollen/Painful Joints			
Skin Problems			
Dizziness			
Loss of Balance			
Fainting			
Double Vision			
Blurred Vision			
Ringing in Ears			
Hearing Loss			
Depression			
Irritable			

Mood Changes			
ADD/ADHD			
Allergies			
Prostate Problems			
Impotence/Sexual Dysfun			
Digestive Problems			
Colon Trouble			
Diarrhea/Constipation			
Menopausal Problems			
Menstrual Problem			
PMS			
Bed Wetting			
Learning Disabilty			
Eating Disorder			
Trouble Sleeping			
Ulcers			
Heartburn			
Heart Problem			
High Blood Pressure			
Low Blood Pressure			
Asthma			
Difficulty Breathing			
Lung Problems			
Kidney Trouble			
Gall Bladder Trouble			
Liver Trouble			
Hepatitis (A,B,C)			

Patient or Authorized Person's Signature

_____ _____

Signature Date

Doctor's Signature

Signature

Date

PATIENT'S NAME: _____ HR#: _____ DATE: _____

INSPIRE CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Inspire Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

Inspire Chiropractic **Dr. Josh Hasty**
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This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: **_____ - retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Inspire Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Inspire Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse Name: _____
- ☐ Significant Other Name: _____
- ☐ Parent/Legal Guardian Name: _____
- ☐ Child(ren) Name(s): _____
- ☐ Any Specified Person Name: _____
- ☐ Information is not to be discussed with or released to anyone.

Restrictions:

- ☐ No Restrictions
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ☐ my home ☐ my work ☐ my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

I understand I may terminate this consent at any time by giving written notice to Inspire Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____