Expedition Chiropractic

PEDIATRIC HISTORY FORM

Today's Date: _____ PM#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

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

Address: _____ City: _____ State: ____ Zip: _____

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: _____

Email address:_____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

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

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes- if yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes- **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes- **If yes**, whom? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes- **If yes,** please explain:

_____

Has your child ever sustained an injury in an auto accident? ○ No ○ Yes- **If yes,** please explain:

_____

PRENATAL HISTORY

QUESTIONS 11-16 are in reference to the prenatal history of the child.

11. Are you the birth mother of the child? ○Yes ○ No

12. List the name of the Doctor/ Midwife:_____

13. Did the birth mother smoke during the pregnancy? ○Yes ○ No- Explain:_____

14. Did the birth mother drink alcohol during the pregnancy? ○Yes ○ No Explain: _____

15. Did the birth mother exercise during the pregnancy? ○Yes ○ No Explain: _____

16. Did the birth mother experience any complications, serious illnesses, or health emergencies during the pregnancy?

○Yes ○ No Explain: _____

BIRTH HISTORY & INFANCY

17. How many weeks of pregnancy was your child born?_____ weeks

18. Child's Birth weight: _____lbs. _____oz. Birth Height _____ In. APGAR score _____-_____

19. Select the delivery method of your child. ○ Vaginal ○ Vaginal Birth after Cesarean ○ Planned Cesarean

○ Emergency Cesarean

20. Was an intervention or assisted delivery procedure used during the birth of your child? ○No ○ Yes if yes, check all that apply ○ Amniotomy (breaking the water sac) ○ Episotomy (surgical incision) ○ Induction (synthetic labor starting drug) ○ Epidural Anesthetic ○ Local Anesthetic ○ Vacuum Extraction ○ Forceps ○ Other _____

21. Were there any complications during the labor process? ○ No ○ Yes, if yes, Explain _____

_____

22. Was your child breastfed or currently breastfeeding? ○ Yes ○ No

23. Was your child fed formula or currently formula feeding? ○ Yes ○ No

CASE HISTORY & LIFESTYLE

24. At what age did you child began to do the following: Walk_____ Talk _____

25. Has your child received any vaccines? ○ No ○ Yes ○ Delayed Schedule ○ On Schedule

26. Is your child taking any over the counter prescriptions, drugs, vitamins/supplements, or natural remedies? _____

27. Has your child ever taken an antibiotic? ○ Yes ○ No

28. Does your child have any trouble sleeping ○ Yes ○ No

29. Does your child have any social, emotional, or behavioral issues? ○ Yes ○ No if yes, Explain_____

_____

30. List your child's interest or hobbies:_____

QVAS

DIRECTIONS: Fill in your problem(s)/concerns that you are currently experiencing. *Regarding these problem(s)/concern(s)*, please CIRCLE the number that best describes the question being asked.

Problem/ Concern #1_____

1. What is your child's pain/ symptom RIGHT NOW?
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

2. What is your child's TYPICAL or AVERAGE pain/ symptom?
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

3. What is your child's pain/symptom AT ITS BEST? (How close to "0" does your pain get at its best?)
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

4. What is your pain/ symptom child's AT ITS WORST? (How close to "10" does your pain get at its worst?)
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

Problem/ Concern #2_____

1. What is your child's pain/ symptom RIGHT NOW?
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

2. What is your child's TYPICAL or AVERAGE pain/ symptom?
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

3. What is your child's pain/ symptom AT ITS BEST? (How close to "0" does your pain get at its best?)
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

4. What is your child's pain/ symptom AT ITS WORST? (How close to "10" does your pain get at its worst?)
   No Pain _____
   0 1 2 3 4 5 6 7 8 9 10

ACTIVITIES OF LIFE

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

ACTIVITIES:	**EFFECT:**			
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Run	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work/ Chores	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Prescription & Non-Prescription drugs being taken: _____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

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

○ Allergies to _____

○ Other: _____

I understand that I am directly and fully responsible to Expedition 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 **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Informed Consent

REGARDING: Chiropractic Adjustments 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 very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Expedition 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)

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's 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.*

☐ I have not started my menstrual cycle yet.

☐ 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)

_____ ____/____/____  *Witness Initials*
Patient or Authorized Person's Signature Date

Expedition Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to 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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.

3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Steven Barger) at 772-245-7069. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Expedition Chiropractic Patient Privacy 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 Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____ DOB _____

Patient's Signature _____ Date _____

Witness _____ Date _____