



## PEDIATRIC HISTORY FORM

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please complete the following information. We look forward to working with you to build better health for your family.

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### Patient Information

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Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Ph: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Sex: M F Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Referred By: \_\_\_\_\_

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### Parent/Guardian Information

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Name(s): \_\_\_\_\_  
Cell Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ S.S. #: \_\_\_\_\_

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### Purpose for Contacting Us? \_\_\_\_\_

Have you seen others doctors for this condition?: \_\_\_\_\_ N \_\_\_\_\_ Y

Other Health Problems? \_\_\_\_\_

Check any of the Following Conditions Your Child has Suffered from during the Past Six Month:

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Colds
<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> ADHD
<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Growing/Back Pain	<input type="checkbox"/> Colic	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Car Accident	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Other: _____	

Family History/Health Problems? \_\_\_\_\_

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Previous Chiropractor: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Number of Doses of Antibiotics Your Child has Taken:  
During the Past 6 Months: \_\_\_\_\_, During Last Year: \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken:  
During the Past 6 Months: \_\_\_\_\_, During Last Year: \_\_\_\_\_

Number of Doses of Over-the-Counter Medications Your Child has Taken:  
During the Past 6 Months: \_\_\_\_\_, During Last Year: \_\_\_\_\_

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**Prenatal History**

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Complications During Pregnancy? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Medications During Pregnancy/Delivery? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Location of Birth: \_\_\_\_\_ Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home

Birth Intervention: \_\_\_\_\_ Forceps \_\_\_\_\_ Vacuum Extraction \_\_\_\_\_ Caesarian Section

Complications During Delivery? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Genetic Disorders or Disabilities? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_, \_\_\_\_\_

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**Feeding History**

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Breast Fed? \_\_\_\_\_ N \_\_\_\_\_ Y, How Long: \_\_\_\_\_

Formula Fed? \_\_\_\_\_ N \_\_\_\_\_ Y

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**Developmental History**

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Please list any falls your child has had in the past (i.e. from changing tables, stairs, bed, bike, tub, etc.).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Is/has your child been involved in any impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Has Your Child Ever Been Involved in a Car Accident Over 3mph? \_\_\_\_\_ N \_\_\_\_\_ Y, When: \_\_\_\_\_  
List Details: \_\_\_\_\_

Has Your Child Been Seen on an Emergency Basis? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Other Traumas Not Described Above? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

Prior Surgery? \_\_\_\_\_ N \_\_\_\_\_ Y, List: \_\_\_\_\_

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**Childhood Diseases**

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Chicken Pox	N	Y, Age _____	Mumps	N	Y, Age _____
Rubella	N	Y, Age _____	Whooping Cough	N	Y, Age _____
Rubeola	N	Y, Age _____	Other	N	Y, Age _____

Please list all others: \_\_\_\_\_

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**Other Information**

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What percentage (%) of the day does your child...

\_\_\_\_\_ play outside or exercise?

\_\_\_\_\_ play videos games/watch TV/play on computer?

\_\_\_\_\_ engage in activities? (church, sports, school, etc.) Please List: \_\_\_\_\_

Rate your child's food intake: 1 2 3 4 5 6 7 8 9 10  
(Poor – Processed Foods/TakeOut/Fast Food) to (Organic, Fresh, Healthy)

Rate your child's school performance: 1 2 3 4 5 6 7 8 9 10  
(Poor) (Average) (Outstanding)

What could improve? \_\_\_\_\_

How many days per year does your child miss school due to illness? 0 1-2 3-6 7 or more

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**AUTHORIZATION FOR CARE OF MINOR**

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I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office at time that services are rendered.

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash       Check       Credit Card/Debit Card       Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand LifeSource Health & Wellness will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to LifeSource Health & Wellness will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

4. For your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (or Guardian authorizing care): \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_



**TERMS OF ACCEPTANCE AND CONSENT FOR CARE**  
**THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE**

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the LIFESOURCE HEALTH & WELLNESS to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

I, \_\_\_\_\_ have read and fully understand the above statements.

(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

**FOR MINORS:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_,

(Print Guardian Name)

(Print Minor's Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)



## Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at LifeSource Health & Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Erica Berns or Dr. Jonathan Berns. If you would like further information about our privacy policies and practices please contact: Dr. Erica Berns or Dr. Jonathan Berns.

This notice is effective as of January 1<sup>st</sup>, 2007. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date