TURNING LEAF CHIROPRACTIC

Child and Adolescent Health Profile

Personal Information

Patient Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Mother's Name: _____ Employer: _____

Work Address: _____

Work Phone: _____ Type of Work: _____

Marital Status: _____ Email Address: _____

Father's Name: _____Employer: _____

Work Address: _____

Work Phone: _____ Type of Work: _____

Marital Status: _____ Email Address: _____

Has the child been seen by a chiropractor before: Yes No

If yes, what was the reason for those visits? _____

Chiropractor's Name: _____ Date of last visit: _____

Reason for leaving? _____

Has any adult in your family seen a chiropractor? Yes No

Has any other child in your family seen a chiropractor? Yes No

Whom may we thank for your son/daughter's referral? _____

Goals For Your Child's Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program.
Please check the type of care desired so that we may be guided by your wishes wherever possible.

☐ **Relief Care**- Symptomatic relief of pain or discomfort.

☐ **Corrective Care**- Corrective and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive Care**- Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

☐ I want the doctor to select the type of care appropriate for my condition.

Thank you for choosing our chiropractic office. We are excited about the possibility of assisting you and your family on your journey towards greater health and wellness. Chiropractic is a lifestyle and a family affair. We give you the opportunity to have your immediate family members examined at no additional charge as long as these exams are done within two weeks.

Part 1: Mother's Pregnancy and Labor

Mother's Name: _____ Birthdate: _____

Did you carry full term? Yes No

Describe any complications and when they occurred: _____

_____

Did you use a midwife? Yes No | Hospital? Yes No | Obstetrician? Yes No

Did you have a C-Section? Yes No | Were forceps used? Yes No | Vacuum extraction? Yes No

Were you induced? Yes No | Epidural? Yes No | Was it a difficult birth? Yes No

Did you breastfeed? Yes No | Feeding problems? Yes No

Did you consume alcohol during your pregnancy? Yes No | How much? _____

Did you smoke? Yes No | How much? _____ | How long? _____

Part 2: Patient Health History

Has your son/daughter ever:

...taken antibiotics? Yes No _____

...had surgery? Yes No _____

...been hospitalized? Yes No _____

...been in a car accident? Yes No _____

As a baby/toddler, (birth to 4years), did any of the following occur?

___Fall from a changing table
___Tumble down the stairs
___Fell out of the crib
___Frequent bouts of Diarrhea
___Tonsillitis
___Fell off playground equipment
___Frequent crying spells
___Frequent Fevers
___Frequent ear infections
___Reaction to a vaccine
___Did not gain weight
___Other: _____
___Sleeping Problems
___Frequent Colds
___Constipation
___Colic
___Car accident

_____

As a young child, (5-12 years), did any of the following occur?

___Fall from a tree
___Sports Accident
___Scoliosis
___Learning Difficulties
___Leg/Knee Pain
___Fall off playground equipment
___Car Accident
___Bed Wetting
___Asthma
___Other: _____
___Fall off bicycle
___Stomach Pains
___Hyperactivity/Autism
___Allergies

Please explain the above: _____

_____

Have you chosen to vaccinate your son/daughter? Yes No

If yes, please circle all that your child has received: DTP MMR Chicken Pox Hepatitis Other

Describe any and all reactions to the vaccines: _____

Please check each of the diseases or conditions that your son/daughter has 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 possibility of being accepted for care.

___Allergies
___Headaches
___Fatigue
___Stomach Problems
___Foot/ankle/knee pains
___Numbness in arms/hands
___Growing pains
___ Digestive problems
___Asthma
___Breathing problems
___Hyperactivity
___Ear problems
___Tingling in arms/legs
___Neck/back pain
___Frequent colds
___Other: _____
___Attention problems
___Dizziness
___Sleeping problems
___Weight gain/loss
___Arm/wrist pain
___Shoulder pains
___Skin problems

Part 3: Current Health

Patient Name: _____ Date: _____

Describe the purpose of this visit: Wellness New Injury Chronic Condition Other

Please Explain: _____

Is this visit related to: (circle all that apply) Sports Auto Fall Home Injury Other

Please Explain: _____

When did this condition begin? _____

Has the condition (circle one) Gotten Worse Stayed Constant Comes and Goes

Does this condition interfere with (circle all that apply) Sleep Daily Routine Other

Please Explain: _____

Has this condition occurred before? Yes No

Please Explain: _____

Has your child seen any other doctors for this condition? Yes No

Doctor's Name(s) _____

Type of Treatment _____

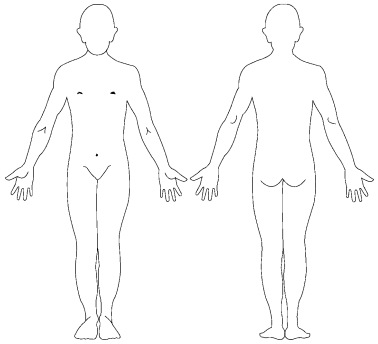
Results _____

Please list any and all medications (prescription and non-prescription) that your child has taken within the past 60 days:

_____

_____

Please circle areas of pain or discomfort:



Please list any herbs, nutritional supplements or natural home remedies your child takes regularly:

_____

_____

I understand that services are to be paid in full at time of service, unless other arrangements have been made and agreed to in writing. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

_____ _____

Parent/Representative Signature: *Date:*

AUTHORIZATION FOR CARE

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

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. T ray negatives will remain the property of this office. They are kept on file where they may be seen at any ti while I am a patient in this office.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnose or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,_____ have read and fully understand the above statements.
Print patient name

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to m complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Patient/Parent/Representative Signature Date

Consent to evaluate and adjust a minor child

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

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent only needs to obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at anytime during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient/Parent/Representative Signature Date