PEDIATRIC PATIENT INTRODUCTION CARD

Date:_____

Child's Name:_____Age:_____Date of Birth:_____Sex: M F

Street Address:_____City, ST, Zip:_____

Parent's Names:_____

Phone:_____Email:_____

Whom may we thank for referring you to our office?_____

Reason for coming to our office:_____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Preferred Phone #:_____

Address (if different than above):_____

Insurance Company:_____Name of Insured:_____

Relationship to Patient:_____Date of Birth:_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Is this dysfunction getting progressively worse? ___Yes ___No

Health History

Symptoms: Please check any current or past problems your child has on the list below:

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood disorders
__Broken bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other_____

Name of Pediatrician:_____Date of Last Visit:_____

Current Medications & Vitamins:_____

Past Trauma (falls, sports injuries, accidents, etc)_____

Past Surgeries:_____

Prenatal History

Location of Birth: ___ Home ___ Birthing Center ___ Hospital

Complications during pregnancy: Y - N List: _____

Medications during pregnancy/delivery: _____

Cigarette / Alcohol use during pregnancy: Y - N

Birth intervention: ___ Forceps ___ Vacuum ___ Caesarian

Complications during delivery: Y - N List: _____

Birth weight_____ Birth length_____

Feeding history

Breast Fed: Y - N How long'?_____ Formula fed: Y - N How long'?_____ Type:_____

Introduced to cereal at____months. Solids at _____ months. Cow's milk at _____ months

Food / juice allergies or intolerances Y - N List: _____

Developmental History

Sleep (Hrs per night) _____ Problems sleeping _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y – N

If yes, please

explain:_____

Has your child been vaccinated? Y – N Adverse reactions to any

vaccine?_____

Childhood Diseases

___Chicken Pox : Age ____ * ___ Mumps: Age ____ * ___ Rubella: Age ____ * ___ Whooping cough: Age ____

___ Measles: Age ____ * ___ Meningitis: Age ____ * ___ Tuberculosis: Age ____ * ___ Other: Age ____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____ , as the parent/guardian of this child, _____ , hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date

GreenLeaf Chiropractic

Informed Consent

We encourage and support a **shared decision making** process between us regarding your healthcare needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order for you to knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may include: Graston, RockTape, and Cupping in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE GREENLEAF CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Print Patient Name: _____

Authorized Signature: _____ Date_____

Relationship to Patient (if not self):_____

GreenLeaf Chiropractic

Notices of Privacy Practices

HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
** Obtain payment from third-party payers
** Conduct normal healthcare operations such as quality assessment and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you take action relying on this account.

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever she may designate as her assistant to administer treatment, physical examination, X-rays studies, laboratory procedures, chiropractic care or any clinic services that she deems necessary in my case: and I further authorize her to disclose all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 Chiropractic Office 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. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

Print Patient Name: _____

Authorized Signature: _____ Date_____

Relationship to Patient (if not self):_____