PEDIATRIC PATIENT HISTORY

Dear Parent

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

CHILD'S NAME:

DOB: M__ F __ HEIGHT WEIGHT:

ADDRESS:

BEST NUMBER TO REACH **PARENT**? HOME ___ CELL ___ WORK____	NUMBER:
OTHER PHONE:	CELL PROVIDER: ATT ___ VERIZON___ T MOBILE ___ OTHER _____

MAY WE LEAVE A MESSAGE? ___ CELL CARRIER:_____

MAY WE SEND MONTHLY APPT. TEXT REMINDER _____

MAY WE EMAIL PERSONAL HEALTH INFORMATION?_____

EMAIL ADDRESS:

NAME OF PEDIATRICIAN:

DATE OF LAST VISIT:

ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED ❑ Y ❑ N

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: _____ LAST 6 MONTHS _____ LIFE

VACCINATION HISTORY:

INSTRUCTIONS: *Check any of the following conditions your child has suffered from in the past six months:*

❑ EAR INFECTIONS	❑ SCOLIOSIS	❑ CHRONIC COLDS
❑ HEADACHES	❑ COLIC	❑ GROWING/BACK PAINS
❑ TEMPER TANTRUMS	❑ SEIZURES	❑ ASTHMA/ALLERGIES
❑ DIGESTIVE PROBLEMS	❑ ADHD	❑ CAR ACCIDENT
❑ RECURING FEVERS	❑ BED WETTING	❑ OTHER_____

DEVELOPMENTAL HISTORY

IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.) ❑ N ❑ Y LIST_____

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT ❑ N ❑ Y LIST_____

HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS? ❑ N ❑ Y LIST_____

PRIOR SURGERY ❑ N ❑ Y LIST_____

MENARCHE: ❑ N ❑ Y AGE:_____

PARENT INFO

NAMES OF PARENTS/GUARDIANS:

PURPOSE FOR CONTACTING US?

PRIOR DDRS. AND TREATMENTS GIVEN FOR THIS CONDITION:

OTHER HEALTH CONCERNS:

REFERRED BY:

TYPE OF BIRTH

Check all that apply

❑ NORMAL VAGINAL	❑ EPIDURAL	❑ FORCEPS
❑ SUCTION	❑ BREECH	❑ CESAREAN
❑ HOME BIRTH	❑ HOSPITAL BIRTH	
BIRTH WEIGHT	BIRTH LENGTH	APGAR _____; _____

PRENATAL HISTORY

NAME OF OBSTETRICIAN/MIDWIFE:

COMPLICATIONS DURING PREGNANCY ❑ N ❑ Y LIST_____

ULTRASOUNDS DURING PREGNANCY ❑ N ❑ Y NUMBER_____

MEDICATIONS DURING PREGNANCY ❑ N ❑ Y LIST_____

CIGARETTE/ALCOHOL USE DURING PREGNANCY ❑ N ❑ Y

FEEDING HISTORY

BREAST FED: ❑ N ❑ Y HOW LONG?_____

FORMULA FED: ❑ N ❑ Y HOW LONG?_____ TYPE?_____

Allen Chiropractic Wellness Center
1018 S Westwod Blvd, Ste. #5
Poplar Bluff, MO 63901

Allen Chiropractic
Wellness Center

1018 S. Westwood Blvd., Ste. 5
Poplar Bluff, MO 63901

Phone: 573-778-0500
Fax: 888-972-7541

www.allenchiropracticwellness.com

AUTHORIZATION FOR CARE OF MINOR

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine the results your child receives.

I hereby authorize Dr Laurie M Allen, and staff of the clinic, to administer care to my

Son ____ Daughter _____

(name): _____

as deemed necessary at Allen Chiropractic Wellness Center.

This authorization is valid if I am not present at the time of treatment. YES ___ NO ___

I clearly understand and agree that I am personally responsible for payment of all fees

charged by this office at time of service.

Signed: _____

Date: _____

Witnessed: _____

Date: _____

ALLEN CHIROPRACTIC WELLNESS CENTER
1018 S WESTWOOD BLVD STE 5, POPLAR BLUFF, MO 63901
573-778-0500 HIPAA FAX : 888-972-7541

NAME : _____

DOB: _____

AUTHORIZATION FOR CARE

I hereby authorize the Dr. Allen to work with my condition using recommended protocols as she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

FINANCIAL POLICY / NO SHOW FEE

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at time of service. I agree that I am responsible for all bills incurred at this office.

- Your health care is very important to us. ***We expect you to keep scheduled appointments.***
- *Late arrival may require your appointment to be rescheduled.*
- *Should you need to reschedule, however, please call our office 24 HOURS in advance to* ***avoid being charged our regular office fee.***
- *Please understand that someone else in pain may need that time. We appreciate your cooperation in this matter.*
- *We manage our schedule to keep you and others from waiting a long time.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. *A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: