Blau Chiropractic PEDIATRIC HISTORY FORM

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.

Patient Name: ______________________ S.S. #: __________

Address: ______________________ City: __________

State: __________ Zip: __________ Home Phone: __________

Birth Date: ____/____/____ Work Phone: __________

Sex: ______ Weight: ______ Height: ______ Referred By: __________

Names of Parents / Guardians: ______________________

Purpose For Contacting Us? ______________________

Other Doctors Seen for this Condition: ____N ____Y, Doctor's Names and Prior Treatments: __________

____

Other Health Problems? ______________________

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing / Back Pains
- ☐ Other______

Family History: ______________________

Previous Chiropractor: ______________________

Date of Last Visit: ____/____/____ Reason: __________

Name of Pediatrician: ______________________

Date of Last Visit: ____/____/____ Reason: __________

Are You Satisfied with the Care Your Child has Received There? ____N ____Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: ______, Total During His / Her Lifetime: ______

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: ______, Total During His / Her Lifetime: ______ List: __________

Vaccination History: ______________________

Prenatal History:

Name of Obstetrician / Midwife: ______________________

Complications During Pregnancy ? ____N ____Y , List: __________

Ultrasounds During Pregnancy ? ____N ____Y , Number: ____

Medications During Pregnancy / Delivery? ____N ____Y , List: __________

Cigarette / Alcohol Use During Pregnancy? ____N ____Y

Location of Birth: ____Hospital ____Birthing Center ____Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction

_____ Ceasarian Section, Emergency or Planned?

Complications During Delivery? _____ N _____ Y List _______________

Genetic Disorders or Disabilities: _____ N _____ Y List _______________

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y How Long: _____

Formula Fed: _____ N _____ Y How Long: _____ Type: _______________

Introduced to Solids at: _____ Months, Cow's Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y, List: _______________

____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractor for prevention and early detection of vertebral subluxation (spine nerve interference).
At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? _____ N _____ Y

Is / Has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Marital Arts, etc.)? _____ N _____ Y List: _______________

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Has Your Child Ever Been involved in a Car Accident? _____ N _____ Y List: _______________

Has Your Child Ever Been Seen on an Emergency Basis? _____ N _____ Y List: _______________

Other Traumas Not Described Above ? _____ N _____ Y List: _______________

Prior Surgery: _____ N _____ Y List: _______________

Menarche: _____ N _____ Y Age: _____

Childhood Diseases:

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

**WE ARE HERE TO SERVE YOU, AND TO ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION AND CARE OF MINOR

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.

Name of Insurance Company: _______________ Policy #: _______________

Signed: _______________ Witnessed: _______________ Date: _____ / _____ / _____

Office Fee Schedule and Financial Policy

Services

Consultation	N/C
Initial Exam/Computer Scans	$80
Dynamic Exam/Computer Scans	$75
X-Rays (per view)	$50
Adjustment	$60
Light Therapy	$25
Vibration Therapy	$30/15min
Nutrition Consultation	$45/30min
Pettibon/Rehab	$30/15min
Wellness Adjustment Plans	Varies per persons needs

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service, unless you are participating in a Care Plan. These are Care Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report. Balances with no payment over 30 days will be charged a $5.00 statement fee, this charge will occur each month until arrangements have been made or balance is paid in full. Patient balances over 60 days will be forwarded to a collection agency with any accrued interest.

- ☐ **Cash Policy: Payment is due at time of service or according to the plan of your choice.**

- ☐ **Health Insurance:** If you have Insurance that covers chiropractic care, we will send in your claims for you. Deductibles and co-pays are paid at time of service, or paid according to the plan of your choice. Remember, **your agreement with your insurance company is between you and them.** Please submit any requested information to them as quickly as possible. Any balance due to denied or reduced claims will be **your responsibility.** Having Insurance does not always guarantee payment.

If you acquire insurance for a special situation such as an auto accident or worker's compensation please let us know immediately. Once a claim is complete, you can return to your original Care Plan.
I have read and I understand the above policies. I have checked the one that applies to me.

Patient Signature ____________________ Date ____________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Blau Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, light therapy, Pettibon, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamenous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the proceeding list but also include the remote possibility of cervebrovascular injury, or stroke (very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who 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 subluxation.

Other treatment options that could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.

Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or Questions

Please ask your Doctor of Chiropractic. Be assured Blau Family Chiropractic has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of Chiropractic Treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

____

Date

____________________________ ____________________________

Signature of Patient or Parent Printed Patient Name

Notice of Information Practices

Protecting the privacy of your health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operation will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you for up to 7 years.

In the future, we may contact you for appointment reminders, missed appointments, announcements and to inform you about out practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting out Office Manager.

I ______________________________ have read and understand this notice.

______________________________ Phone Number ________________________ Date __________

Signature

The effective date of this Notice of Information Practices is 10/02/2006.