PEDIATRIC HEALTH HISTORY

Welcome to Beyond Wellness Chiropractic

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. Please print clearly and fill this out completely prior to your appointment time.

Patient Information

Date:_____

Name:_____Nickname:_____

Male / Female (circle one)

Birth Date:_____Age:_____Social Security #:_____

Parents Name(s):_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Mom Cell Phone:_____

Dad Cell Phone:_____Parents Email:_____@_____

Would you like to be on our mailing list (Email newsletter): Y N

Insurance Company (if applicable):_____

Whom may we thank for referring your child?_____

Health Information

Please check the reason(s) for pursuing chiropractic care for your child:

___She/he is continuing ongoing care from another chiropractor.

___I recently had my spine checked and I see the value in getting my child checked.

___I'm concerned about his/her health and I'm looking for answers.

___I want to improve my child's immune function.

___I'm not sure why we're here. Please take the time to explain to me what you do for children.

___She/he has a specific condition that concerns me.

Please explain condition or symptom:_____

_____

When did the condition or symptom appear?_____

Has the condition or symptom been getting: Worse Better Same (circle one)

Who has your child seen for this problem?_____

Prenatal History

Is your child adopted? No Yes (circle one)

Complications during pregnancy? No Yes List:_____

Complications during delivery? No Yes List:_____

Birth Intervention: ____Mother Medicated (Pitocin, etc.) ____Caesarian Section ____Forceps

____Vacuum Extracted ____Emergency

Genetic Disorders or Disabilities? No Yes List:_____

Health History

Has your child ever seen a chiropractor before?_____Approx. date of last adjustment?_____

Names of other doctors who have cared for your child:_____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_____

Medications and Supplements your child is taking (include over the counter medicine and contraceptives):

_____

_____

Number of rounds of Antibiotics taken: During last 6 months:_____ In lifetime:_____

Reasons:_____

Number of rounds of other Prescription Medicines taken: During last 6 months:_____ In lifetime:_

Reasons:_____

In order for us to better understand your child's current level of health, please check any of the following body signals which your child is experiencing now, or has in the past:

	Now	Past		Now	Past		Now	Past		Now	Past
Headaches	( )	( )	Postural Imbalance	( )	( )	Asthma	( )	( )	Growing/Back Pains	( )	( )
Allergies	( )	( )	Ear Infections	( )	( )	Scoliosis	( )	( )	Digestive Problems	( )	( )
ADD/ADHD	( )	( )	Autism	( )	( )	Seizures	( )	( )	Frequent Colds	( )	( )
Bedwetting	( )	( )	Sinus Problems	( )	( )	Colic	( )	( )	Car Accident	( )	( )

Other:_____

Trauma History

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e.: a bed, changing table, down stairs, etc.).

Was this the case with your child? No Yes

List:_____

Is/was your child involved in any high impact or contact type sports (i.e.: soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? No Yes

List:_____

Has your child been seen on an Emergency basis? No Yes

List:_____

Has your child ever had surgery? No Yes

List:_____

Has your child ever been involved in a car collision? No Yes

List:_____

Any other traumas not described above?

List:_____

Authorization and Releases

Fees are due and payable at the time of examination, x-rays and adjustments unless other arrangements are made in advance. The fee paid for x-rays is for analysis only. The film itself is the property of the office. Once films are used for care purposes they cannot be released directly to the patient. However, they may be released to another physician with the properly signed release and must be returned to this office within 14 days of the release.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that Beyond Wellness Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. Also, any amount to be paid directly to Beyond Wellness Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am responsible for payment.

_____ _____

Parent or Guardian Signature Date

Please initial where indicated and sign below in the event that any of the following occur.

_____**Consent for care**

(**Initial**)-I, the undersigned, being the parent or legal guardian of _____, hereby authorize Dr. Nicole Reiter (and whomever she may designate as her assistant), to administer care as necessary to my minor child.
-I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

_____ _____

Parent or Guardian Signature Date

Fees are due and payable at the time of examination, x-rays and adjustments unless other arrangements are made in advance. The fee paid for x-rays is for analysis only. The film itself is the property of the office. Once films are used for care purposes they cannot be released directly to the patient. However, they may be released to another physician with the properly signed release and must be returned to this office within 14 days of the release.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that Beyond Wellness Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. Also, any amount to be paid directly to Beyond Wellness Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am responsible for payment.

_____ _____

Parent or Guardian Signature Date

Authorization to release Health Care Information

_____**Authorization to release health care information**

(Initial)-I authorize the release of any health care information to process my insurance claim(s) and also certify that all insurance information given to Beyond Wellness Chiropractic is correct and complete. I permit this office to endorse remittances for the conveyance of credit to my credit. I understand that this office will prepare any necessary reports and forms to assist me in making collection receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me that I am personally responsible for payment.

_____**Attorney representation and protection of balance**

(Initial)-I, the undersigned patient am directing my Attorney/Insurance Adjuster, _____

To pay any outstanding bills out of my settlement, and in effect, to protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's protection and consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover any fees for services. I have been advised that if my attorney/insurance adjuster does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

_____ _____

Parent or Guardian Signature Date

Consent for Use and Health Care Information Authorization

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services, i.e. insurance provider.
- We may need to use your health information to market services or products that we have available, e.g. birthday cards, promotional announcements, kids wall, patient of the week programs and other promotions as they occur, referral program, thank you letters, etc)
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your name, address, e-mail address, phone number, and you clinical records to contact you with appointment reminders, information about treatment alternative, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on you answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices; we will notify you in writing when you come in for an office visit or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restriction on the use or disclosure of you health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if your health information was released prior to your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Signature Authorized Provider Representative

_____ _____

Signature Date

_____

Date

X-Ray Findings

Date_____

C.A._____

"Our policy is to report our exam and x-ray findings to all patients. We would never want to x-ray our patients needlessly. Therefore, please sign below to acknowledge your agreement to return to our office to receive the doctor's report on the findings from your exam and x-rays."

Print Name_____

Signature_____ Date_____

TERMS OF ACCEPTANCE

BEYOND WELLNESS CHIROPRACTIC

NICOLE B. REITER, DC
JOHNS ISLAND, SC 29455

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name_____

Signature_____ Date_____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read
Parent/Guardian Name Child's Name
and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature_____ Date_____