maxliving DELONG FAMILY CHIROPRACTIC

Pediatric Health History Form

Child's Name: _____ Date: _____ Patient Number: _____

Parent Names: _____ Sibling's Names & Ages: _____

Child's Age: _____ Birth date: _____ (mm/dd/yyyy) Sex: □ M □ F

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Other Number:_____

Email address: _____

Family doctor's name: _____ Address:_____

Who may we thank for referring you?_____

Please check the purpose for your child's visit:

□ crisis management □ early detection of problems □ prevention
□ wellness □ maximizing normal growth and development □ other: _____

Present Health Concerns

Please identify the condition(s) that brought your child to our office and on a scale of 1 to 10 with 10 being the worst possible pain and 0 being no pain, rate your child's conditions:

Major_____ 0—1—2—3—4—5—6—7—8—9—10
Minor_____ 0—1—2—3—4—5—6—7—8—9—10

When did this problem begin?_____

Is this problem: □ occasional □ frequent □ constant □ intermittent

Does problem radiate? □ *Yes* □ *No* If Yes, where? _____
What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of the day? □ *Yes* □ *No*
If Yes, when?_____

Does this interfere with the child's sleep? □ *Yes* □ *No* Eating? □ *Yes* □ *No* Daily routine? □ *Yes* □ *No*

Is this becoming worse? □ *Yes* □ *No*

Has your child ever received chiropractic care? □ Yes □ No

If yes, who is your child's previous Doctor of Chiropractic? _____

The date of last visit:_____

The reason for the last visit:_____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent test done (list date beside): □ Bloodwork _____ □ Urine _____ □ X-rays _____ □ Other: explain

_____

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Often seemingly unrelated symptoms can manifest as other health concerns… Please mark if your child has had any of the following

□ headaches	□ chest pressure	□ weight loss
□ dizziness	□ breast pain	□ weight gain
□ irritability	□ frequent colds	□ dental problems
□ fatigue	□ sinus congestion	□ fevers
□ depression	□ sore throats	□ heart palpitations
□ loss of balance	□ ear pain/infections	□ numbness in feet
□ loss of concentration	□ asthma	□ numbness in hand(s)
□ fainting	□ cold sweats	□ weakness
□ ears buzzing	□ bronchitis	□ heartburn
□ poor coordination	□ pneumonia	□ muscle cramps
□ vision changes	□ difficulty breathing	□ upper back pain
□ loss of memory	□ shortness of breath	□ neck pain
□ loss of smell	□ allergies	□ low back pain
□ loss of taste	□ constipation	□ radiating pain
□ light sensitivity	□ diarrhea	□ sleeping problems
□ face flushed	□ urinary problems	□ numbness in leg(s)
□ reduced mobility	□ bloating/gas	□ stiffness

Birth History

What was the child's gestational age at birth? ____ weeks.
Birth weight _____lbs. _____oz Birth length _____ inches

Was your child's birth: □ at home □ in a birthing center □ hospital □ other
Was the birth considered: □ medical □ midwife Duration of birth: _____ hours
Was child born: □ cephalic (headfirst) □ breech (feet first)

Were there any complications? □ *Yes* □ *No* If Yes, please explain _____
Assistances used during delivery: □ Forceps □ Vacuum extraction □ C-section □ Episiotomy
Was labor: □ spontaneous □ induced Were medications or epidurals given to the mother during birth? □ *Yes* □ *No*
APGAR score: at Birth _____/10 After 5 minutes___/10

Is there anything else we need to know about the birth □ Yes □ No

Pediatric Health History Form

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? □ *Yes* □ *No*
If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Does your child sleep: □ front □ back □ side

Do you consider the child's sleeping pattern normal? □ *Yes* □ *No* How many hours per day? _____
If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:
Mothers family _____
Fathers family _____
Siblings _____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) □ *Yes* □ *No*
If yes, please explain _____
_____

Any evidence of birth trauma to the infant?

□ *bruising* □ *odd shaped head*

□ *stuck in birth canal* □ *fast or excessively long birth*

□ *respiratory depression* □ *cord around neck*

Any falls from couches, beds, change tables, etc.? □ *Yes* □ *No*

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? □ *Yes* □ *No*
If yes, please explain _____

Any hospitalizations or surgeries? □ *Yes* □ *No*
If yes, please explain _____
Any sports played? _____
Is a school backpack used? □ *Yes* □ *No* Is it □ heavy or □ light?

Pediatric Health History Form

Chemical Stressors

Was this child breast-fed? □ *Yes* □ *No* If yes, how long: _____
Formula introduced at what age: _____ Which formula? _____
Introduction of cow's milk at what age: _____ Began solid foods at what age: _____
Types of solid foods: _____

Food/Juice intolerance? □ *Yes* □ *No*

Type: _____

Do you use non-toxic products in your home? _____

Is your child on or have taken any medications? _____

Is your child circumcised? □ *Yes* □ *No*

Has your child received any vaccinations? □ *Yes* □ *No*

Please indicate which vaccine your child has received and when.

Birth - Hep B □ *Yes* □ *No* Vitamin K □ *Yes* □ *No*

1-2 Months - Hep B □ *Yes* □ *No*

2 Months - DtaP □ *Yes* □ *No* Hib □ *Yes* □ *No* IPV □ *Yes* □ *No* PCV □ *Yes* □ *No* RV □ *Yes* □ *No*

4 Months - DtaP □ *Yes* □ *No* Hib □ *Yes* □ *No* IPV □ *Yes* □ *No* PCV □ *Yes* □ *No* RV □ *Yes* □ *No*

6 Months - DtaP □ *Yes* □ *No* Hib □ *Yes* □ *No* PCV □ *Yes* □ *No* RV □ *Yes* □ *No* Influenza □ *Yes* □ *No*

6-18 Months - HepB □ *Yes* □ *No* IPV □ *Yes* □ *No* Influenza □ *Yes* □ *No*

12-15 Months - Hib □ *Yes* □ *No* MMR □ *Yes* □ *No* PCV □ *Yes* □ *No* Chickenpox □ *Yes* □ *No*

12-23 Months - HepA □ *Yes* □ *No* Influenza □ *Yes* □ *No*

15-18 Months - Dtap □ *Yes* □ *No* Influenza □ *Yes* □ *No*

4-6 Years - Dtap □ *Yes* □ *No* MMR □ *Yes* □ *No* IPV □ *Yes* □ *No* Varicella □ *Yes* □ *No* Influenza □ *Yes* □ *No*

During the mother's pregnancy:

Did the mother smoke? □ *Yes* □ *No* How much? _____
Drink alcohol? □ *Yes* □ *No* How much? _____
Any illnesses during the pregnancy? □ *Yes* □ *No* If yes, describe: _____
Any supplements taken during pregnancy? □ *Yes* □ *No* If yes, describe: _____
Any drugs taken during pregnancy? □ *Yes* □ *No* _____
Any ultrasounds? □ *Yes* □ *No* How many: _____
Reasons for being done:_____
_____
Any invasive procedures during pregnancy (i.e. amniocentesis, Chorionic villi sampling, etc.)? □ *Yes* □ *No*

If yes, please explain _____

Any pets at home? □ *Yes* □ *No* _____
Any smokers in the home? □ *Yes* □ *No*
Any antibiotics given? □ *Yes* □ *No* If yes, reason: _____

Pediatric Health History Form

Is the diet organic? □ *Yes* □ *No* *Do you use 'green products' in your home for cleaning?* □ *Yes* □ *No*

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? □ *Never* □ *On weekends* □ *A few times per week* □ *Daily* □ *Nearly each meal* □ *On special occasions*

Are you aware of the impact of nutrition on children's behavior*?* □ *Yes* □ *No*

Would you like information on nutrition for your child*?* □ *Yes* □ *No*

Psychosocial Stressors

Any difficulties with lactation? □ *Yes* □ *No* _____

Any problems with bonding? □ *Yes* □ *No* _____

Any behavioral problems? □ *Yes* □ *No* _____

Any inattention? □ *Yes* □ *No* _____

Any hyperactivity or restlessness? □ *Yes* □ *No* _____

Any compulsiveness? □ *Yes* □ *No* _____

Any difficulties at daycare or school? □ *Yes* □ *No* _____

Any challenges with learning deficiencies? □ *Yes* □ *No* _____

Any night terrors, sleep walking, difficulty sleeping? □ *Yes* □ *No* _____

Any prolonged temper tantrums or separation anxiety? □ *Yes* □ *No* _____

Is the child in day care □ *Yes* □ *No* _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work □ *Yes* □ *No* _____?

Is the child home schooled? □ *Yes* □ *No* _____by Whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? □ *Yes* □ *No* How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? □ *Yes* □ *No*

_____

Pediatric Health History Form

Often seemingly unrelated symptoms can manifest as other health concerns… Please mark if your child has had any of the following

□ poor hand-eye coordination	□ difficulty catching a ball	□ poor balance
□ easily distracted	□ messy handwriting	□ skipping parts of a line when reading
□ difficulty copying from a blackboard	□ poor pencil grip	□ poor fine motor skills
□ messy handwriting; poor pencil grip	□ poor spelling	□ stick out tongue when writing
□ slouching at the desk or computer	□ difficulty to process ideas	□ poor verbal expression & articulation
□ over sensitive and reactive to sensory stimulus	□ poor impulse control and highly reactive	□ easily distracted and hyperactive
□ loss of concentration	□ asthma	□ numbness in hand(s)
□ social and emotional immaturity	□ anxiety and unable to adapt well to change	□ mood swings
□ motion sickness	□ poor balance and coordination	□ thumb sucking
□ chewing on hair, sucking on sleeves	□ difficulty with speech and pronunciation	□ poor posture and coordination
□ lack of ability to sit still	□ lack of attention and concentration	□ clumsiness
□ bedwetting and poor bladder control	□ late crawler or skip crawling	□ poor muscle tone
□ tendency to slump while sitting	□ inability to sit still	□ lack of concentration
□ poor organizational and planning skills	□ difficulty sitting upright	□ poor muscle tone
□ tendency to walk on toes	□ motion sickness	□ poor balance
□ poor posture	□ short term memory difficulty	□ difficulty swimming the breaststroke
□ weak upper body		

Pediatric Health History Form

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

Pediatric Health History Form

HIPPA Law #101-191 Consent Form

The information you provide us is kept in the strictest of confidence.
While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health information.

1. It may be necessary to use or disclose your private health information to another health care provider or hospital, if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health issue.
2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purpose including:
   a. appointment reminders at home
   b. appointment reminders at work
   c. leaving messages on a voicemail or answering machine
   d. testimonials of your improvement in written or verbal form
   e. sending you marketing materials
   f. information about alternative treatments
   g. other health related information that may be of interest to you
   h. "Thank you" correspondence

Patients' Rights Under HIPPA Law #101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies, or organizations under the following circumstances:
   a. all request must be in writing
   b. by law we are not required to agree with your restrictions however, if we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your authorization under certain conditions.
   a. it must be in writing
   b. the request will not be honored if we have already released your private health information before we received your request to revoke the authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance may hat the right to our private health information, should they decide to contest any of your claims. Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone that has access to the remainder of other information and may no longer be protected by the federal privacy rules.
   c. If you do not give us authorization, it will not affect the treatment we provide to our patients or the methods we use to obtain reimbursement for services rendered to you.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records. This notice is effective on the date below and will expire seven years after the date upon which the record was created.

_____	_____
Print your name	Authorized Signature
_____	_____
Signature	Date

- Note: We have a more detailed notice of "Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by posting of the changes in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Pediatric Health History Form

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully
In order for Dr. DeLong to make a determination on the suitability of my child's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. DeLong, or any party authorized to do so by that person.

I have had the opportunity to discuss with Dr. DeLong, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: _____ Date: _____

Signature: _____ Witness: _____

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature

Pediatric Health History Form

ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

OUR OFFICE POLICIES

Welcome to DeLong Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care***, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **DeLong Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Palmer Package. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining

the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	__ _____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	