PANGEA CHIROPRACTIC PEDIATRIC/ADOLESCENT HISTORY FORM

WHO MAY WE THANK FOR **REFERRING YOU**?_____

Confidential Patient Information

Today's Date _____/_____/____ Please check box if you don't want text reminders □

Child's Name_____

Date of Birth _____/_____/_____ Age: _____

Address _____

City _____ State _____ Zip _____

Mother's Name: _____ Mother's Mobile _____

Father's Name: _____ Father's Mobile _____

Pediatrician/Family Practitioner _____City/State _____

Who is responsible for this bill? _____

Current Health Condition:

Purpose of this visit: □ Wellness □ Injury or Accident □ Other

1.What health condition(s) bring your child to be evaluated by the Pangea doctors:

_____

_____

2.If your child is experiencing Pain/Discomfort; please identify where and for how long:

_____

_____

When did the problem first begin? Date ___/___/___ □ Unknown □ Gradual □ Sudden

1) Ever had this problem before? □ Yes □ No
   If yes, when? _____
2) Have you seen any other doctors for this issue? □ Yes □ No
   Who? _____
   How long? _____
   Result of past treatment: _____
3) How is this problem NOW? □ Improving □ Worse □ Same
   □ On & Off □ Unsure

3.Has your child ever sustained injury in organized sports? □ Yes □ No

If yes, please explain:_____

_____

4.Has your child ever been in an auto accident? □ Yes □ No

If yes, please explain:_____

_____

5.Has your child ever suffered a concussion? □ Yes □ No

If yes, how many? _____Have they ever been evaluated for concussive healing? □ Yes □ No

6.Has your child been vaccinated? □ Yes □ No

If yes: □ Up-to-date: □ Delayed List any reactions:_____

7.Please list any drugs/medications/vitamins/herbs other that your child has or is taking: _____

_____

Pregnancy & Fertility History:

Please tell us about your pregnancy

1. Any fertility issues? □ Yes □ No If yes explain: _____
2. Did mother smoke? □ Yes □ No If yes explain: _____
3. Did mother drink? □ Yes □ No If yes explain: _____
4. Did mother exercise? □ Yes □ No If yes explain: _____
5. Was mother ill? □ Yes □ No If yes explain: _____
6. Any ultrasounds? □ Yes □ No If yes explain: _____

Please list any notable episodes of mental or physical stress during your pregnancy:

_____

_____

_____

Labor and Delivery History:

Please check:

□ Vaginal Birth □ Scheduled C-Section □ Emergency C-Section (At how many weeks was your child born?____)

□ Home Birth □ Birthing Center □ Hospital

Please check any applicable interventions:

□ Breech □ Induction □ Pain Meds □ Epidural □ Episiotomy □ Vacuum □ Forceps

Please list any concerns or notable remarks about your child's birth/delivery or postpartum recovery for mom:

_____

_____

Growth & Development History:_

1. Did your child have any delays or challenges in any of the following:
   □ Respond to sound □ Vocalization □ Following objects
   □ Sitting unassisted □ Crawling □ Walking □ Toilet Training
   If yes, explain:_____
   _____
2. Has your child received any antibiotics? □ Yes □ No
   a. If yes, at what age?_____ How many times?_____
3. How many hours per day does your child watch TV, use a computer, tablet or phone? _____
4. How would you describe your child's diet? □ Mostly whole, organic foods □ Pretty average □ Highly processed
5. My child's diet includes: □ Gluten □ Dairy □ Soy □ Processed sugars

Pangea Chiropractic Pediatric/Adolescent Conditions

Has your child ever suffered:

Check all that apply:

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□ Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Asthma
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Walking Trouble
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Sleeping Problems
□ Bed Wetting	□ Colic	□ Broken Bones	□ Eating Disorder
□ Fall off bicycle	□ Fall from bed or couch	□ Fall from crib	□ Harming of others/animals
□ Fall off swing	□ Alcohol Usage	□ Fall down stairs	□Suicidal Thoughts/tendencies
□ Fall off skateboard/skates	□ Drug Usage	□ Anger/Rage	□Self Harm ie. cutting/burning

□ Allergies to environment_____

□ Allergies to food_____

□ Other:

_____

_____

_____

Additional Information for the Doctor:

_____

_____

_____

_____

_____

Acknowledgement & Consent:

I understand that I am directly and fully responsible to Pangea Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

□ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Name _____

Patient/Guardian Signature _____ Date _____

Pangea Chiropractic HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment : We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third Party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent,

Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization. Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints： You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before January 1st 2014.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print: Patient/Guardian Name_____Signature_____

Date _____