

## PEDIATRIC HISTORY FORM

### PATIENT DEMOGRAPHICS

HR#: \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Birth Height: \_\_\_\_ Birth Weight: \_\_\_\_ Current Height: \_\_\_\_ Current Weight: \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Mother's Mobile \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Father's Mobile \_\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_ City/State \_\_\_\_\_

Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for visit: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

☐ Father's Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ☐ Mother's Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_☐ Other (please explain): \_\_\_\_\_

### CHILD'S CURRENT PROBLEM:

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Please explain: \_\_\_\_\_

*If your child is experiencing Pain/Discomfort please identify where and for how long*1. When did the Problem first begin? Date \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Unknown ☐ Gradual ☐ Sudden2. Ever had this problem before? ☐ No ☐ Yes If yes, when? \_\_\_\_\_

3. Any bowel or bladder problems since this problem began?: If yes, describe: \_\_\_\_\_

4. Have you seen any other doctors for this problem? ☐ No ☐ Yes If yes, who? \_\_\_\_\_

5. How long ago? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

6. What were the results of past treatment? \_\_\_\_\_

7. How is this problem NOW?: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same  
☐ Gradually Worsening ☐ On & Off

8. Please list any medication taken for this problem: \_\_\_\_\_

9. Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes If yes; please explain:

---

---

---

10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes If yes; please explain:

---

---

---

**HAS YOUR CHILD EVER SUFFERED FROM: Check all that apply**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Orthopedic Problems    | <input type="checkbox"/> Digestive Disorders        | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Neck Problems          | <input type="checkbox"/> Poor Appetite              | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Arm Problems           | <input type="checkbox"/> Stomach Aches              | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions     | <input type="checkbox"/> Leg Problems           | <input type="checkbox"/> Reflux                     | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Joint Problems         | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches         | <input type="checkbox"/> Backaches              | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Walking Trouble     |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Broken Bones               | <input type="checkbox"/> Fall off swing      |
| <input type="checkbox"/> Fall in baby walker      | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib             | <input type="checkbox"/> Fall down stairs    |
| <input type="checkbox"/> Fall off bicycle         | <input type="checkbox"/> Fall from high chair   | <input type="checkbox"/> Fall off slide             |  |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Fall off skateboard/skates |  |

☐ Allergies to \_\_\_\_\_

☐ Other: \_\_\_\_\_

I understand that I am directly and fully responsible to Baker 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

## **PATIENT POLICY: DOCTOR-PATIENT AGREEMENT**

### **Welcome to Baker Family Chiropractic & Neuropathy**

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

#### **PATIENT POLICY: SIGNING IN**

When you arrive to our office, please sign in. You will be called and assigned a treatment room in order you signed in for your doctor. Other patients treated by another doctor may be called before you because their doctor is available, not because they are taken out of turn.

#### **PATIENT POLICY: PAYMENT OF BILLS**

We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. We do not bill patients. If we are forced to bill you, you will receive a service charge. Our policy is that patients have a zero cash balance.

Insurance companies will be billed. Any checks sent to your home by the insurance company should be brought or sent to the office within three days. Please also send the attached stub to indicate which services were paid. Failure of the patient to make payment of an overdue account or to otherwise communicate will result in unnecessary upset.

We will expect insurance co-payments to be pre-paid at the first visit of each week.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

#### **PATIENT POLICY: MISSING OR CHANGING APPOINTMENTS**

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, be sure to make up the missed appointment within the same week. **If you miss/cancel an appointment without a twenty-four (24) hour notice, there will be a service charge of \$35.** If you miss three consecutive appointments, either by cancellation or no show, without a valid excuse it is under the doctor's discretion to release you from care.

#### **PATIENT POLICY: PROGRESS EVALUATIONS AND RE-EXAMINATIONS**

During your treatment series, progress evaluations and check-ups may take place. The fee for these services should be paid for according to the payment agreement made with our office.

## **PATIENT POLICY: DIETS AND FOOD SUPPLEMENTS**

Diets should be followed and food supplements taken if recommended. Any problem you may have with these recommendations should be communicated. We do not prescribe, but will make recommendations to help speed your recovery. You are expected to pay for food supplements at the time of purchase.

## **PERSONAL INJURY PATIENTS**

Baker Family Chiropractic requires payment in full at the time of service. If payment cannot be made at the time of service, most automobile policies provide medical payment coverage. Pursuant to the terms of ones automobile insurance policy, medical bills will be billed under the medical payment coverage.

## **CONSENT FOR TREATMENT**

I, the undersigned, authorize Baker Chiropractic and Neuropathy to perform appropriate examination procedures and to administer treatment which is considered by them to be therapeutically necessary based on the examination findings and findings during the course of treatment. I understand that Baker Chiropractic Neuropathy will, upon my request, explain to me why the treatment is considered necessary and inform me as to the disadvantages, risks and possible complications from said treatment as well as alternative methods of treatment. I also understand that there are no guarantees as to the results that may be obtained from treatment.

I also agree to receive emails regarding my care, treatment plan or statement of account. I also understand and agree that Baker Chiropractic and Neuropathy utilizes a text system to confirm appointments and communicate to me about my appointments and to ask for feedback regarding my treatment.

I have read the above and I understand and accept these policies.

---

Patient's Signature

---

Date

## CASE HISTORY

Name: \_\_\_\_\_ Have you ever been to a chiropractor? Y / N Last visit \_\_\_\_\_

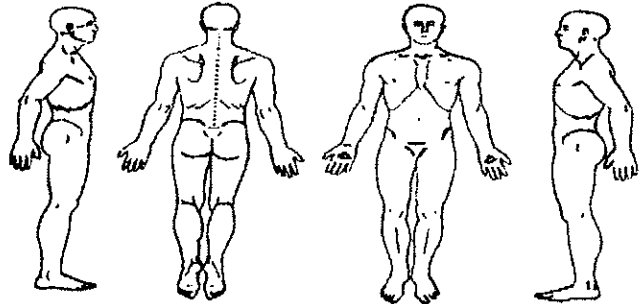
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning                      -Increase during the day  
-afternoon                    -same all day  
-night                          -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? \_\_\_\_\_

6. How did your symptoms begin? \_\_\_\_\_

7. Have you experienced these before? \_\_\_\_\_

8. Do your symptoms radiate? \_\_\_\_\_

9. Has your condition? \_\_\_\_ Improved \_\_\_\_ Gotten Worse \_\_\_\_ Stayed the same since it began

10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? \_\_\_\_ No \_\_\_\_ Yes Describe: \_\_\_\_\_

If No, what have you tried that has not helped? \_\_\_\_\_

12. Have you been treated for this before? \_\_\_\_ No \_\_\_\_ Yes How long ago? \_\_\_\_\_

13. What treatment did you receive? \_\_\_\_\_

14. Results of previous treatment? \_\_\_\_ Good \_\_\_\_ Poor Comments \_\_\_\_\_

15. Were you referred to our office by anyone? \_\_\_\_\_

16. Is this condition interfering with \_\_\_\_ Work \_\_\_\_ Sleep \_\_\_\_ Daily Routine \_\_\_\_ Recreation

17. List any other major injuries you have had, other than those mentioned above: \_\_\_\_\_

18. Any other Musculoskeletal problems? \_\_\_\_ No \_\_\_\_ Yes ...Neurological problems? \_\_\_\_ No \_\_\_\_ Yes

PCP Name/Number: \_\_\_\_\_

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent

### **REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Baker Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature      Date       *Witness Initials*

### **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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature      Date       *Witness Initials*

## **BAKER CHIROPRACTIC NOTICE OF PRIVACY PRACTICE**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### **PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### **YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### **COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Gayle at (513) 561-2273. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

Patient initials: \_\_\_\_\_-retaining page 1 of 2

***BAKER CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...***

I have received a copy of Baker Chiropractic Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date