PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date ____/____/____

Childs 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 ☐ Sudden
2. **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*

☐ 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	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ 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

JDD, DC 5/2011

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

Baker Chiropractic

4625 Red Bank Rd. Suite 101, Cincinnati, OH 45227
(513) 561-2273

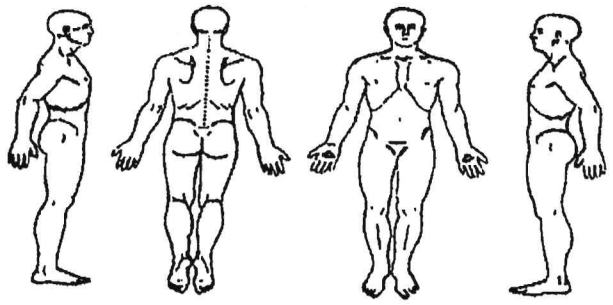
CASE HISTORY

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 (Minimal → Severe)	Frequency (% of week) (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: _____

Baker Chiropractic

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.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

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 Date

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 apprize 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	