STROMBERG CHIROPRACTIC

757 Fife Avenue | Wilmington, OH 45177 | P (937)382-1727 | F (937)383-2597

Pediatric New Patient Paperwork

Please fill out this form to the best of your abilities and return to the front desk. Let us know if you have any questions!

Pediatric Patient Information

Patient Information

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Phone Number _____

Date of Birth_____ Age_____ Gender □M □F

In case of emergency, contact

Name_____ Relationship_____

Contact Number_____

Mother's Name _____ Father's Name _____

Mother's Occupation _____ Father's Occupation _____

Mother's Phone _____ Father's Phone _____

Mother's Email _____ Father's Email _____

Who may we thank for referring you? _____

Has your child been checked by a Doctor of Chiropractic? Yes No

If yes, please provide the name of the office & doctor. _____

Were x-rays taken Yes No

How can we help your child? □Wellness Checkup
□Other_____
_____
_____

If your child is already experiencing a symptom(s), please describe:
_____
_____
_____

When did this symptom(s) appear? _____

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Has your child been treated for this symptom(s) on an emergency basis? □Yes □No If Yes, please describe:

_____

_____

Is the problem: □Constant □Intermit □Cyclic

Effect on activity? □Not at all □ Somewhat □ Always

Pregnancy History:

Did mother experience any complications during her pregnancy? (check all that apply)

□ Back / Other Pain □ Gestational Diabetes □ Pre/Eclampsia □ Strep B □ Nausea / Vomiting
□ Pre-Term □ Fatigue □ Swelling □ Other (please describe)_____

Was the mother under chiropractic care during pregnancy? □ Yes □ No

Last adjustment? _____

Has child had previous chiropractic care? □ Yes □ No

Last adjustment? _____

Birth History:

Type of Birth (check all that apply):

□ Hospital □ Birth Center □ Scheduled/Induced □ Home □ Normal/Vaginal □ Breech
□ Cesarean □ Epidural □ Forceps □ Vacuum Extraction

Problems during labor / delivery:

□ Antibiotics □ Congenital Anomalies □ Failure to Thrive □ Respiratory Distress □ Meconium
□ Jaundice □ Extended Hospitalization □ Other_____

Was labor induced? □ Yes □ No If yes, why? _____

What position did you deliver in? □ Squatting □On back □ Other

Birth Trauma? □Doctor assisted □Twisting and/or Pulling □Vacuum Extraction

Did your child have a misshaped skull / head? □Yes □No

Did you breast feed your child? □Yes □No

Does your child prefer one breast over the other? □Yes □No

If yes, which side □Right □Left

Does your child have any food allergies? □Yes □No

If yes, please list: _____

Have you vaccinated your child? □ Yes □ No □ As Scheduled □ Delayed Schedule

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Did your child have any negative reaction to the vaccinations? □Yes □No

Has your child ever had any surgeries? □Yes □No

If yes, please elaborate. _____

Has your child ever been hospitalized? □Yes □No

If yes, please elaborate._____

Has your child been on antibiotics? □Yes □No

If yes, how often and what for? _____

Is your child currently taking any medication? □Yes □No

Is your child currently taking any vitamins? □Yes □No

Growth and Development

Infant Feeding: □ Breast □ Bottle □ Formula

Number of hours of sleep each night: _____

Number of times they wake each night: _____

At what age did the child:

Respond to sound_____ Hold head up_____ Sit unsupported_____

Crawl_____ Stand_____ Walk unsupported_____

Is this condition interfering with:

□ School □ Sleep □ Concentration □ Daily Routine □ Other _____

Baby / Toddler (0-4): Have any of the following occurred?

□Colic □ Constipation □Fall from a changing table □ Fall out of crib □Fall off of playground equipment
□Frequent crying spells □Frequent diarrhea □Frequent ear infections □Frequent fevers
□Motor Vehicle Accident □Play in a Johnny Jumper □Reaction to vaccines □Repeated infections or colds
□Sleeping problems □Tonsillitis □Tumble down stairs □Weight gain
□Other (Please explain):_____

Child (5-12): Have any of the following occurred?

□Allergies □Asthma □Bed wetting □Fall from a tree □Fall off of a bicycle □Fall on playground
□Hyperactivity/Autism □Learning difficulties □ Leg / Knee pains □ Motor Vehicle Accident □ Scoliosis
□Sports accident □Stomach pains □ Other (Please explain): _____
How would you rate your child's diet? □Well balanced □ Average □High sugar / processed foods

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Childhood Diseases, Illnesses, & Vaccinations

Has your child ever suffered from (check all that apply)?:

□ ADD/ ADHD □ Allergies □ Arm Problems □ Asthma □ Back Aches □ Bed Wetting

□ Behavioral Problems □ Broken Bones □ Chronic Ear Aches/ Infections □ Colds/ Flus □ Colic

□ Convulsions/Seizures □ Dark circles under eyes □ Delayed Speech □ Diabetes □ Dizziness

□ Digestive Issues (constipation/diarrhea) □ Fainting □ Falls □ Headaches □ Head/Sports injuries

□ Heart Trouble □ Hyperactivity □ Insomnia □ Jaw/TMJ Problems □ Joint Problems □ Leg Problems

□ Motor Vehicle Accident □ Neck Problems □ Neuritis □Orthopedic Problems □Paralysis

□ Poor Appetite □Rashes □ Runny Nose □Ruptures/hernias □Scoliosis □Sinus Trouble

□Stomach Aches □Walking Problems □Other _____

I certify the information provided is accurate to the best of my knowledge:

Patient Name (printed): _____

Signature: _____

Parent/Guardian Name (printed): _____

Date: _____

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CONSENT FOR TREATMENT OF MINOR

We, the undersigned, parent(s)/person having legal custody/legal guardianship of _____ (child's name) a minor (under the age of 18), do hereby authorize consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Minor (print name): _____

Parent/Legal Guardian (print name) _____

Parent/Legal Guardian (Signature) _____

Date _____/_____/_____

Witness_____ Date _____/_____/_____

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Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient Name: _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____