Pediatric Patient History Form

Welcome to The Cafe of Life Chiropractic!
Please take a moment to fill out this form and sign the bottom.
Thanks! We will take GREAT care of you here!

Child's Name:_____ Date of Birth:_____
Mother's Name:_____ Father's Name:_____

Address_____City_____State_____Zip_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Sex: M or F Birth Weight:_____ Current Weight:_____
Email:_____Who referred you to our office?_____
Type of Birth: Normal/Vaginal:_____ Forceps:_____Breech:_____
Home:_____Hospital:_____Cesarean:_____
Problem during pregnancy?_____
_____
Problem with labor/delivery?_____
_____
APGAR Scores:_____Present at Birth? Jaundice(yellow)_____Cyanosis(blue)_____
Congenital Anomalies/Defects:_____
Infant Feeding: Breast _____ Bottle:_____Formula:_____
Quality of Sleep: Good:_____Fair:_____Poor:_____
Immunization History:_____
Any childhood diseases?_____
Purpose of last visit to MD:_____
Purpose of this appointment:_____
_____
Development History: At what age did the child…?
Smile:_____ Stand:_____Walk Alone:_____Crawl:_____Hold objects with hands:_____
Has this child ever suffered from: (Check all that apply)

Dizziness_____	Behavioral problems_____	Arm problems_____	"Growing Pains"_____
Diabetes_____	Backaches_____	Ruptures/hernias_____	Stomach Aches_____
Anemia_____	Headaches_____	Blood Disorders_____	Chronic Ear Aches_____
Poor Appetite_____	Digestive Disorder_____	Heart Trouble_____	Cold/Flu_____
Bed Wetting_____	Rheumatic fever_____	Diabetes/hypoglycemia_____	Allergies_____
Fainting_____	Hyperactivity_____	Paralysis_____	Constipation_____
Neck Problems_____	Seizures_____	Broken Bones_____	Diarrhea_____
Joint Problems_____	Walking Problems_____	Leg Problems_____	Asthma_____

** Any other:_____
Surgeries_____
Medications_____
Accidents_____
Family History_____
Has your child ever been treated on an emergency basis: Yes or No If so, why?_____
Do you have any type of health insurance? Yes or No Company name:_____ ID #:_____
** Please provide us with your insurance card so we may photocopy it.

Consent to Treat a Minor

I agree to assume responsibility for any charges created by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Joshua Siegel.
Parental Signature:_____ Date:_____

Welcome to the Café of Life!

TERMS OF CASE ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustments: An adjustment is the specific application of forces to facilitate the body's connection of vertebral subluxation. My chiropractic method of connection is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

I do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, I encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis or treatment of those findings, I will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. My ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. My only method to eliminate this interference is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statement.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(signature) **(date)**

Consent to Evaluate and Adjust a Minor Child

I, _____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

End of last menstrual period: ____/____/____

_____ _____

(signature) **(date)**

Café of Life Health Care Authorization Form

Name:_____

SS #_____Date of Birth_____

THE PERSON IDENTIFIED ABOVE AUTHORIZES THE DOCTORS AT THE CAFÉ OF LIFE TO USE AND OR DISCLOSE PROTECTED HEALTH (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to the Doctors at the Café of Life to use my address, phone number and clinical records to contact me with appointment reminders, missed reservation notification, birthday cards, holiday related cards, information about treatment alternative or other health related information.
2. If the Café of Life contacts me by phone, I give permission to leave a phone message on my answering machine or voicemail.
3. I give the Café of Life permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of PHI during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. I also consent to signing the guest book and understand it may be viewed by others.
4. By signing this form you are giving Café of Life permission to use and disclose your PHI in accordance with the directives listed above.
5. I authorize my insurance company to pay to the chiropractor or chiropractic group on all insurance submissions.
6. I authorize the chiropractor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

EXPIRATION

The Authorization shall expire on the following date:_____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.
You may revoke this authorization by mailing or and delivering a written notice to the Privacy Official of the Café of Life. The written notice must contain the following information:
Your Name, Social Security #, Date of Birth;
A clear statement of your intent to revoke this authorization;
The date of your request and Your Signature.
The revocation is not effective until the Café of Life receives it.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, the Café of Life will not refuse treatment. You have a right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name of Patient_____

Signature of Patient_____

Date_____

Signature of Personal Representative_____