

# PEDIATRIC PATIENT CASE HISTORY

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

**PATIENT INFORMATION**

Child's Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Parent(s)/Guardian(s) Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Home Phone  Other: \_\_\_\_\_

**\*Referred By:** (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

**FAMILY HISTORY** (Please mark X to all that apply and use comments to elaborate.)

Unknown  Unremarkable

Family History Comments:

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT HEALTH**

Is this appointment related to an auto accident?  Yes  No

*If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.*

Have you or your child ever had chiropractic care before?  Yes  No

If yes, please tell us the doctor's name \_\_\_\_\_

Is your child receiving care from other health professionals?  Yes  No

If yes, please name them and their specialty \_\_\_\_\_

Who is your family's primary care physician? \_\_\_\_\_

Please list any drugs or medications your child is taking \_\_\_\_\_

Please list any vitamins/herbs/homeopathic/other your child is taking \_\_\_\_\_

Please list any allergies your child has \_\_\_\_\_

What health condition brings your child to our office? \_\_\_\_\_

When did the symptoms first begin? \_\_\_\_\_

How did the problem start?  Suddenly  Gradually  Post-Injury

Is this condition:  Getting Worse  Improving  Intermittent  Constant  Not Sure

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Has your child ever had a similar condition?  Yes  No

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

Has your child been treated for this problem before?  Yes  No

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

Does your child eat well?  Yes  No Does your child have regular bowel/bladder movements?  Yes  No

Child's birth was:  At home  At a birthing center  At a hospital

My obstetrician/midwife/family physician was \_\_\_\_\_

#### HEALTH HISTORY

Child's birth was:

Natural vaginal (no medications/interventions)

Vaginal with interventions:  Induction  Pain medication  Epidural  Episiotomy  Vacuum extraction

Forceps  Other \_\_\_\_\_

C-section:  Scheduled  Emergency

Please list reasons for any interventions/complications: \_\_\_\_\_

Child's birth weight \_\_\_\_\_ Child's birth height \_\_\_\_\_ Current weight \_\_\_\_\_ Current height \_\_\_\_\_

APGAR score at birth \_\_\_\_\_ APGAR score after 5 minutes \_\_\_\_\_

Was your child alert and responsive within 12 hours of delivery?  Yes  No

If no, please explain \_\_\_\_\_

#### GROWTH DEVELOPMENT

At what age did the child:

Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_ Vocalize \_\_\_\_\_

Sit Alone \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Teeth \_\_\_\_\_

Is/was your child breastfed?  Yes  No If yes, how long? \_\_\_\_\_

Formula introduced at age \_\_\_\_\_ What type? \_\_\_\_\_

Introduction of cow's milk at age \_\_\_\_\_ Began solid foods at age \_\_\_\_\_

Please list any foods/juice intolerance \_\_\_\_\_

Did mother smoke during pregnancy?  Yes  No Did mother drink alcohol during pregnancy?  Yes  No

Any illness/falls/accidents of mother during pregnancy?  Yes  No

If yes, please explain including treatment/medications/supplements \_\_\_\_\_

List any drugs/medications (including over the counter) taken during pregnancy \_\_\_\_\_

List any supplements taken during pregnancy \_\_\_\_\_

Any exposures to ultrasound?  Yes  No

If so, how many and what was the medical reason? \_\_\_\_\_

Any pets at home?  Yes  No

Any smokers at home?  Yes  No

Has child received any vaccinations?  Yes  No

If yes, which ones and list any reactions \_\_\_\_\_

Has child received any antibiotics?  Yes  No

If yes, how many times and list reason \_\_\_\_\_

Any difficulty with lactation?  Yes  No

Any difficulty with breastfeeding?  Yes  No

If yes, please explain \_\_\_\_\_

Any difficulty with bonding?  Yes  No

If yes, please explain \_\_\_\_\_

Any behavioral problems?  Yes  No

If yes, please explain \_\_\_\_\_

Age child began daycare \_\_\_\_\_ Average number of hours of TV/Computer/iPad per week \_\_\_\_\_

Does your child seem normal for their age?  Yes  No

If no, please explain \_\_\_\_\_

Does your child play sports?  Yes  No Number of hours per week? \_\_\_\_\_ Age child began \_\_\_\_\_

Approx. Weight of school backpack? \_\_\_\_\_ lbs Approx. Hours spent at play per week? \_\_\_\_\_ Hrs

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year



5145 N FM 620 Ste F-130 Austin, Tx 78732

### **HIPAA Notice of Privacy Practices**

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

If you have any questions about the above notice, please contact our Privacy Officer, Dr. Jimmy Allgood at (512) 276-2710.

#### **Our Obligations**

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

#### **How We May Use and Disclose Health Information**

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

#### **Special Situations**

**As required by law.** We will disclose Health Information when required to do so by international, federal, state, or

local law.

**To Avert a Serious Threat to Health or Safety.** We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

**Your Rights**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

**Changes to This Notice**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

**Complaints**

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date



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Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

**Terms of Acceptance**

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

**AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.

**AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**CMS-1500 HEALTH INSURANCE CLAIM FORM:** By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

**ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Patient Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_



5145 N FM 620 Ste F-130 Austin, Tx 78732

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Chiropractic Services**

**By reading below I have been made aware:**

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed **manually, with a table mechanism, or with an instrument** to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of **electricity, traction, motion, nutritional advice, heat, or cold;**
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore by signing below:**

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_



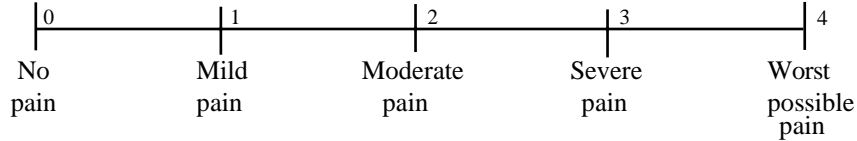
# Functional Rating Index

For use with Neck and/or Back Problems only.

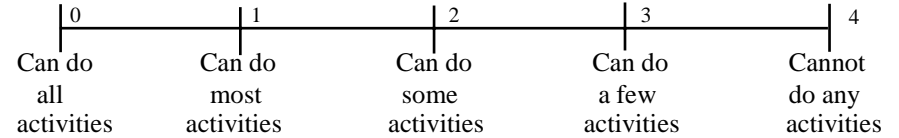
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

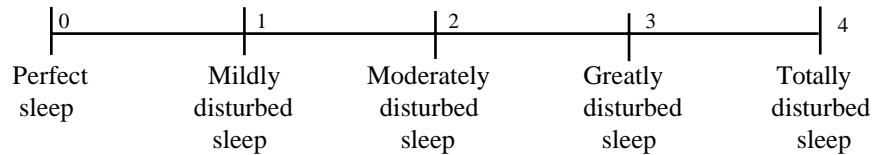
## 1. Pain Intensity



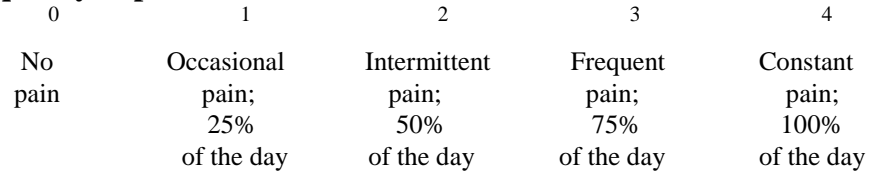
## 6. Recreation



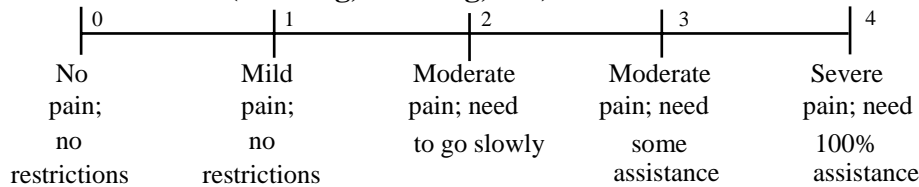
## 2. Sleeping



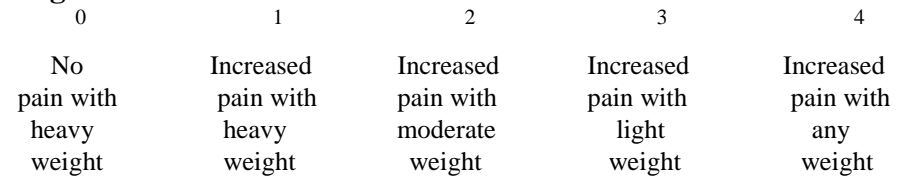
## 7. Frequency of pain



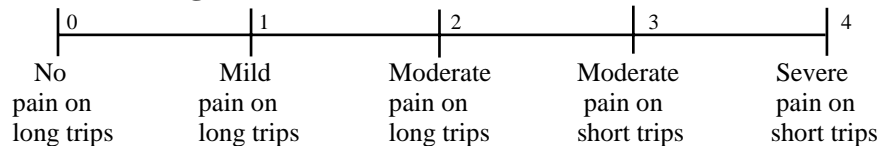
## 3. Personal Care (washing, dressing, etc.)



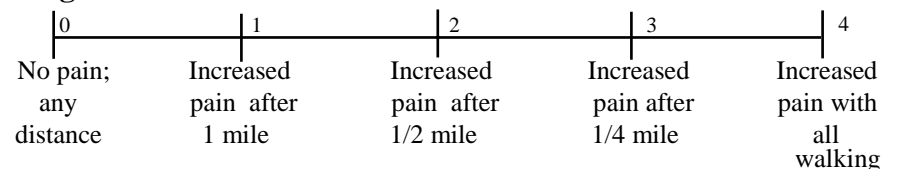
## 8. Lifting



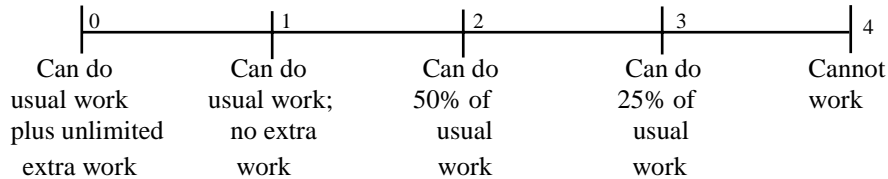
## 4. Travel (driving, etc.)



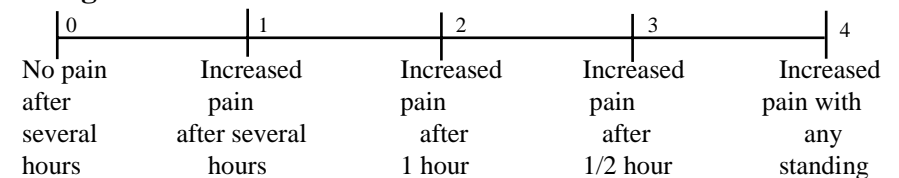
## 9. Walking



## 5. Work



## 10. Standing



Name \_\_\_\_\_ ID#/SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

PRINTED

Signature

Date