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# Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with you child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name_____ Date of Birth_____ Pt. # _____

Address_____ City/State_____ Zip_____

Home Phone_____ Parent's work phone _____ Parent's Cell _____

Mother's Name_____ Father's Name _____

Names and Ages of Siblings _____

Reason for consulting our office _____

Social Security # _____

Previous Chiropractic Care? Y/N If yes, with whom? _____

How long was care received? _____ Last Check-up_____

Insured's SS# _____ Place of Work _____ Date of Birth _____

**Circle Appropriately**

Birth Place: Home/Birth Center/Hospital

Type: Vaginal/C-section

Procedures: Forceps/Vacuum Extraction

Was delivery long: Y/N Was delivery difficult? Y/N Labor Induced? Y/N

Epidural? Y/N Pain Medication? Y/N

Was baby breech/in utero-constraint? Y/N

Was baby breast fed? Y/N Duration_____

Which sports does/did your child participate in?

None/Soccer/Football/Gymnastics/Cheerleading/Karate/Basketball/Dance

Other(s) _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) during the first year of life. Has this happened to your child? Y/N Comments_____

List any other falls or accidents_____

**OVER**

Check any of the following conditions your child has suffered from:
(Circle 'C' for current, circle 'P' if in the distant past, circle 'R' if in the past 6 months)

| | | |
|---|---|---|
| C/P/R Ear Infections | C/P/R Scoliosis | C/P/R Seizures |
| C/P/R Chronic colds | C/P/R Asthma/Allergies | C/P/R Digestive Problems |
| C/P/R Headaches | C/P/R ADD/ADHD | C/P/R Recurring Fevers |
| C/P/R Growing/Back Pains | C/P/R Colic | C/P/R Bed Wetting |
| C/P/R Constipation | C/P/R Head Banging | C/P/R Other:_____ |

List date and year of any surgeries or hospitalizations _____

_____

**MEDICATION**
How many rounds of antibiotics has your child taken in the last 6 months?_____
Lifetime_____

Present prescription drugs_____

Past prescription drugs_____

Over the counter drugs (past 6 months) _____

**FINANCIAL INFORMATION**
Person responsible for account: _____
Are you planning to use some type of insurance? Y/N

**********

**AUTHORIZATION FOR CARE OF A MINOR**

I hereby authorize DREAM Wellness and whomever they may designate to administer care, as they deem necessary to my son/daughter.
May presence is / is not necessary for care to be rendered (circle one).

Signed:_____

Today's Date: _____

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# Notice of Privacy for:
# Patient's Protected Health Information

**This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that appropriate services have been rendered.
- To determine patient's / practice member's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient / practice member.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign in logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

**You have the right to:**

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer, who is *Brian A. Stenzler, DC*., and can be reached at *858-274-2225* regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients / practice members may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have read and reviewed this notice with full understanding.

_____

Practice Member Name (Print)

_____ _____

Signature of Patient/Legal Representative Date

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# TERMS OF ACCEPTANCE

When a practice member receives services at D.R.E.A.M. Wellness®, it is essential for all parties to be working toward the same objective.

**Chiropractic** has only one goal. It is important that each practice member understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.
**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.
**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.

We 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, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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

**Massage** is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch to promote overall body wellness. The general benefits of massage, possible massage contraindications and the care procedures have been explained to me. I understand that massage is not a substitute for medical treatment, and it is recommended that I concurrently work with a Primary Caregiver for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal adjustments are not part of massage. I have informed the massage therapist of all my known physical conditions and medications currently taking and I will keep my massage therapist updated on any changes.

Any inappropriate comments, advances or gestures made towards the massage therapists or any provider will not be tolerated and will be asked to leave the premises immediately.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the caregiver's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care and/or massage on this basis.

_____ _____
(signature) (date)

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# 24 HOUR CANCELLATION POLICY

This form is to advise you of our office's 24 hour cancellation policy. Due to the overwhelming demand and limited appointment slots, we are unable to hold an appointment time for you if you are not able to keep it. Giving us notice of 24 hours or more allows us to fill the appointment time slot from the waiting list of others needing an appointment.

If you need to cancel your scheduled appointment, please notify us as soon as possible, at the very latest 24 hours prior to your scheduled appointment. If you cancel an appointment with less than 24 hours notice, you will be charged the full fee for the appointment you were scheduled for. (If you are scheduled for a service from a package previously purchased, you will lose that visit.)

By signing below, you acknowledge the above and fully understand the cancellation policy.

_____ _____ _____

Signature Printed Name Date

Credit Card # _____ Exp date _____ CID _____

Only last 4 numbers if we have it on file

Zip Code _____

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## Authorization to Use or Disclose Protected Health Information

Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment, for contact regarding chiropractic care, related health services and/or related health products and for appointment reminders and scheduling related matters as described in the office's privacy policy.

In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients. It is our desire to use your name, address, e-mail and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, products and scheduling related matters.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

Name:

_____

Signed Date

If you are a minor or if you are being represented by another party please provide the appropriate person's:

Name

_____

Signature Date

Relationship to the patient

This authorization expires on: April 1, 2010