FENN CHIROPRACTIC PEDIATRIC HISTORY FORM

Today's Date: __________________ HR#: ____________________

PATIENT DEMOGRAPHICS

Child's Name: _____________________________________ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: ___________ Birth Weight: ___________ Current Height: ___________ Current Weight: ___________

Address: ____ City: ___________________________ State: ____ Zip: ________

Mother's Name: ____ Birthdate: _____-_____-_____

Mother's Phone: Mobile ___________________ Work __________________ E-mail Address: ______________________

Father's Name: ____ Birthdate: _____-_____-_____

Father's Phone: Mobile ___________________ Work __________________ E-mail Address: ______________________

Pediatrician/Family MD: ____ City/State: ____________________________

Last Visit Date: _____-_____-_____ Reason for visit: ____

Who is responsible for this bill? ____

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: ___________________ ○ Mother's Driver's License #: ___________________

○ 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. Has this problem occurred before? ○ No ○ Yes If yes, when? ____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: ___________________________

   ____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? ________________________________
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 and Off
8. Please list any medication(s) taken for this problem: ____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:

____

____

PATIENT'S NAME: ______________________________ HR#: ____________ DATE: __________

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 FENN 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 Completed**

______________________________   _____ - _____ - _____

Doctor's Signature   **Date Form Reviewed**

PATIENT'S NAME: ____ HR#: _______________ DATE: ____________

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 risks are most often very minimal, 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 FENN 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.

____
Patient Name (print)

____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff 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.

____
Patient Name (print)

____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

FENN 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 **P**ersonal **H**ealth **I**nformation. 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 us at (850) 386-7700. If we are unavailable, you may make an appointment with our front desk manager to see the Doctor 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***

FENN CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of FENN CHIROPRACTIC's Patient 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

FENN CHIROPRACTIC NOTICE OF OFFICE POLICIES

As a potential new patient, it is important that you understand our office policies regarding how patients of Fenn Chiropractic are cared for. Please read each policy carefully so that you may understand what you can expect as a patient, as well as what we expect in return. If you have any questions or are uncertain of any statements after you have read the Notice of Office Policies, please let our Front Desk Employees know and a member of our staff will be happy to discuss them with you further. We believe it is in our best interest to provide you, our potential new patient, with as much information as possible about the functionality of our office so that an informed decision can be made as to whether you wish to move forward as a patient.

Over time, individuals who are accepted as patients in this office, gain a greater understanding as to the purpose of chiropractic. Since most of the patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

Please acknowledge the policies below by checking each box.

☐ **PATIENT PRIVACY -** Since most of the patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE -** When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at FENN CHIROPRACTIC is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses 1) Precision Spinal Correction OR 2) a myriad of techniques to accomplish this goal, including but not limited to Clear Institute Diversified, Gonstead, Pierce, Thompson, & Activator. It is important that you understand both the objective and the method(s). Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST -** Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health, and the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS -** To enhance your understanding of the chiropractic approach that will be used to manage your health immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings.' The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for all individuals who wish to become a patient of Fenn Chiropractic. Because the results of your x-rays and examinations as well as the doctor's recommendation for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring/ maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Patient initials: __________**-retaining *page 1 of 2***

FENN CHIROPRACTIC NOTICE REGARDING OFFICE POLICIES continued…

I hereby acknowledge receiving a copy of the practices 'Office Policies,' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice.' I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____________________________	____________	____________
Patient's Name	DOB	HR#

____________________________	____________
Patient's Signature	Date

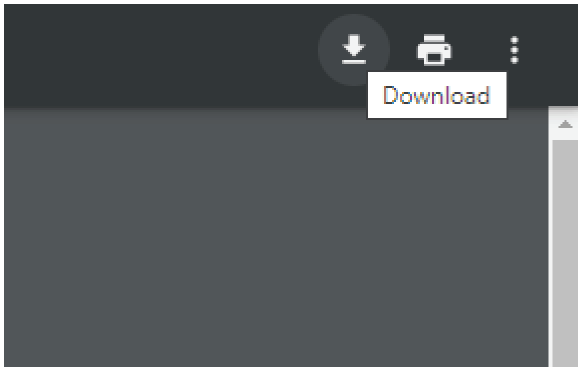
____________________________	____________
Witness	Date

FENN
CHIROPRACTIC

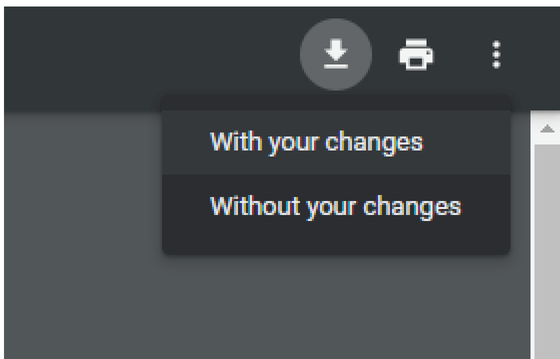
INSTRUCTIONS TO SUBMIT PAPERWORK:

Step 1: Fill in your information in all required fields.

Step 2: When completed, click on 'Download' in the top right-hand corner.



Step 3: Choose the option for "With your changes". Save the file with your first and last name in the file name.



Step 4: Attach the document in an email to **fennchiro@gmail.com**