

PEDIATRIC HISTORY FORM

PATIENT DEMONGRAPHICS

Childs Name _____ Today's Date ____/____/____ HR#: _____

Date of Birth ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Who is responsible for this bill? Father Social Security # _____ - _____ - _____ Mother Social Security # _____ - _____ - _____

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** _____

- When did the Problem first begin?** Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden _____
- Ever had this problem before?** No Yes If yes when? _____
- Any bowel or bladder problems since this problem began?:** No Yes (Describe): _____
- Have you seen any other doctors for this problem?** No Yes If yes who? _____
- How long ago?** _____ Days _____ Weeks _____ Months _____ Years
- What were the results of past treatment?** _____
- How is this problem NOW:** Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off
- Please list any medication taken for this problem:** _____
- Has your child ever sustained an injury playing organized sports?** _____ If yes; please explain _____
- Has your child ever sustained an injury in an auto accident?** _____ if yes; please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: mark a Y for YES OR N NO

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems |
| <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ | |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib |
| <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____ | |

PREGNANCY HISTORY:

Third Trimester Presentation: _____ Vertex _____ Breech _____ Transverse _____ Face/Brow

Type of Birth: _____ Normal vaginal _____ Forceps _____ Cesarean _____ Suction Cap or Vacuum

Location: _____ Home _____ Hospital _____ Birthing Center _____ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had _____

Has your child ever been treated at the emergency room? _____ if yes; please explain _____

Has your child ever been hospitalized? _____ if yes; please explain _____

Has your child ever had any Surgeries? _____ if yes; please explain _____

Is your child currently on any medication? _____ if yes; please list: _____

AT WHAT AGE DID THE CHILD: Respond to sound _____ Follow an object with his/her eyes _____ Sit alone _____

Hold heel up _____ Crawl _____ Stand _____ Walk alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox _____ Mumps _____ Measles _____ Rubella _____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

____ Heart Disease

____ Diabetes

____ Stroke

____ Cancer

____ High / Low blood pressure

____ Asthma

____ Gastrointestinal disease

____ Memory/mood disorder

____ Thyroid problem

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of?

I understand that I am directly and fully responsible to Health From Within for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must, retained these films for a period of no less than 5 years.

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

For Doctors Use Only





NOTICE OF HIPAA PRIVACY PRACTICE

HEALTH FROM WITHIN is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. 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 and return it to our front desk receptionist.

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 available 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 to 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 apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. 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
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

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Danielle LeMonnier at 708-349-0040. If she is unavailable, you may make an appointment with our receptionist to speak with her within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to: HFW 14400 S. John Humphrey Dr. Ste 110 Orland Park, IL 60462.

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Health From Within Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand 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 signature

Date

Witness

Date