PARENT/CHILD HEALTH QUESTIONNAIRE

Date: _____ File #: _____

Name of Child: _____ Preferred Name: _____

Name of Mother: _____ Name of Father: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone Number: _____Date of Birth: _____Age: _____ Sex: M F

Address of Parent (if different from child): _____

What is the purpose of this appointment? _____

_____

Any other concerns? _____

_____

When was your child's last fall or trauma? _____ Was any care given? _____

Was he/she checked by a chiropractor? Y / N

Has your child ever fallen from heights of over 2 feet or had any falls down steps? Y / N If yes, please describe:

_____

Has your child ever been seen on an emergency basis? Y / N If yes, please explain: _____

_____

Please check any of the following conditions that your child has suffered from in the past or present:

□ Allergies	□ Chicken Pox	□ Fatigue	□ Meningitis	□ Rubeola
□ Asthma	□ Colds	□ Fevers	□ Mumps	□ Seizures
□ ADHD / ADD	□ Colic	□ Growing Pains	□ Neck Pain	□ Scoliosis
□ Back Pain	□ Diarrhea	□ Headaches	□ Poor Posture	□ Sleeping Disorders
□ Bedwetting	□ Digestive Problems	□ Irritability	□ Rashes	□ Whooping Cough
□ Breathing Problems	□ Ear Infections	□ Measles	□ Rubella	□ Other: _____

Please list all past and present athletic activities your child has participated in: _____

_____

Has your child ever been involved in an automobile accident? Y / N If yes, please explain: _____

_____

List any other traumas, surgeries, and/or hospitalizations: _____

On a scale of 0 – 10, please describe your child's stress level (0 = None / 10 = Extreme): _____

Is your child on any medication or supplements? (If so, please list) _____

_____

Are you concerned about any developmental delays? (If so, please explain) _____

_____

Do any family members have the same or similar health conditions? If yes, please list family member and explain: _____

CONSENT TO CARE

I, the child's legal parent or guardian, hereby request and consent to the performance of chiropractic adjustments and procedures on my child by the doctor of chiropractic named below:

_____ _____

Signature of Parent/Guardian Date

_____

Name of Child

Dr. Amanda Britten
Family Chiropractor

HIPAA: Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form you will consent to our use and disclosure of your child's protected health information to carry out treatment, healthcare, and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

Right to Change: We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Amanda Britten, DC Pathways Family Chiropractic , 3616 N. 165th St., Omaha, NE 68116 (402) 889-6127.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, healthcare, and practice operations. I also acknowledge that I have received a copy of, and agree to, Pathways Family Chiropractic's Notice of Privacy Practices.

_____ _____

Signature of Parent/Guardian Date

_____

Name of Child

TERMS OF ACCEPTANCE

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each practice member understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

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

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae 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 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

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

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 for my child on this basis.

_____ _____
Signature of Parent/Guardian Date

_____
Name of Child