Pediatric (birth to age 11) Health History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name:_____Date: _____

Parent(s) Name(s):_____

Sibling(s) Name(s) (Ages):_____

Address:_____ City: _____ State: _____

Zip Code: _____ Home Phone: (____)_____Cell Phone: (____)_____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F Referred by: _____

Has your child ever received chiropractic care? ☐ Yes ☐ No

If yes, previous DC's name and last visit date? _____

Name of Medical Doctor: _____

Date of and reason for last MD visit: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____ WORK TEL: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

WITNESS SIGNATURE: _____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. If child was adopted, answer to the best of your knowledge or select ***unsure*** if unknown.

Current Health Concern(s) – please circle or mark appropriate response on each question & elaborate as needed

Does your child have any current health concerns? Yes No, here for wellness

If yes, please elaborate: _____

When did you notice it?_____ How often does it occur?_____

Does it radiate? Yes No If yes, where?_____

What makes it better?_____

What makes it worse?_____

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when?_____

Pages 8-13 of this form are required to be completed only when child is coming in as an individual practice member and not as part of a family membership.

Describe how it interferes with your child's sleep, eating, schoolwork, or hobbies: _____

_____

Do you feel it is getting worse? Yes No If yes, how? _____

0 to 10, what is your child's discomfort level NOW? 0 1 2 3 4 5 6 7 8 9 10 UNKNOWN
0 to 10, what is your child's discomfort level AT WORST? 0 1 2 3 4 5 6 7 8 9 10 When was it last at that level? _____

Other Professionals seen for concern:_____

Treatments received and Results: _____

_____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss Of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness in Leg(s)
☐ Loss of Concentration	☐ Shortness of Breath	☐ Sinus Congestion	☐ Numbness in Feet
☐ Loss of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness in Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: _____

History of Birth:

Ggestational age at birth? _____ Weeks Birth weight: _____ lbs _____oz. Birth length _____inches

Was your child's birth ☐ at home ☐ in a birthing center ☐ in a hospital

Was the birth considered ☐ medical ☐ midwife

What was the duration of the labor and birth? _____ hours

Was child born ☐ Cephalic (head first) ☐ Breech (feet first)

Were there any complications? ☐ Yes ☐ No

If yes, please explain: _____

Please check any assistance which was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

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Was labor ☐ Spontaneous ☐ Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No

If yes, what was given? _____ _____

APGAR score: at Birth _____/10 After 5 minutes _____ /10

Growth and Development:

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain: _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold up head _____ Vocalize _____

Sit alone _____ Teeth _____ Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No

If no, please explain: _____

Family Health History

Please note ages with any health issues (including but not limited to heart disease, cancers, diabetes,…) are present with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

List any other issues or concerns that you want us to be aware of: _____

_____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by inability to adapt to or resolve *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stresses – please circle or mark appropriate response on each question & elaborate as needed

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) Yes No Unsure

If yes, please explain: _____

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal

☐ Fast or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

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Any falls from couches, beds, change tables, etc? Yes No Unsure

If yes, please explain: _____

Any traumas resulting in bruises, cuts, stitches, or fractures? Yes No Unsure

If yes, please explain: _____

Any hospitalizations or surgeries? Yes No Unsure

If yes, please explain: _____

Any sports played? Yes No N/A

If yes, please explain: _____

Is a school backpack used? ☐ Yes ☐ No If yes, is it ☐ Heavy ☐ Light

How many hours of electronic technology (TV, cell phone, tablet, computer) use is your child exposed to daily?

1 2 3 4 5 6 7 8 9 10 10+

Chemical Stresses – please circle appropriate response on each question & elaborate as needed

Is your child currently taking any prescription medications? Yes No

If yes, which ones? _____

Do you routinely use non-prescription medications (i.e. Tylenol) for your child? Yes No

If yes, which ones and how often? _____

Does your child currently take any supplements? Yes No

If yes, which ones? _____

Is your child around tobacco use? Yes (Vape, Cigarettes, Chewable, Pipe, Cigars) No

Has your child been fully vaccinated? Yes No Unsure (please attach a vaccination history, if yes)

Any negative reactions? Yes No If yes, what were they? _____

Has your child ever taken any antibiotics? Yes No Reason?_____

Has your child received annual flu shots? Yes No Unsure

Has your child been tested for MTFHR? Yes No Results? _____

Does your child have any known allergies? Yes No Unsure

If yes, please elaborate: _____

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Please answer the following questions regarding your child's diet – please mark appropriate response on each question & elaborate as needed:

Overall, how much does your child eat in a day?	☐ Too little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily intake of sugar?	☐ Very little	☐ Moderate amount	☐ Too much	☐ Unsure
Daily intake of caffeine?	☐ 0-3 servings	☐ 4-6 servings	☐ >7 servings	☐ Unsure
Daily intake of fatty foods?	☐ 0-3 servings	☐ 4-6 servings	☐ >7 servings	☐ Unsure
Daily fruits and vegetables?	☐ 0-3 servings	☐ 4-6 servings	☐ >7 servings	☐ Unsure
Fast food consumption?	☐ Very little	☐ Moderate amount	☐ Too much	☐ Unsure

How much water (measured in ounces) does your child drink daily? ____ Sodas, milk, & juice do not count as water intake.

Daily goal should be half the body weight in OUNCES- i.e., weight = 50 lbs, daily water intake = 25 oz

Do you have any concerns about your child's diet and nutrition? Yes No

If yes, please explain: _____

Was this child breast-fed? Yes No Unsure If yes, how long? _____

Formula introduced at what age?_____ What formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food / Juice intolerance? Yes No If yes, what type? _____

During pregnancy, did the mother, smoke? Yes No Unsure How much?_____

During pregnancy, did the mother, drink alcohol? Yes No Unsure How much? ___

Any illnesses during the pregnancy? Yes No Unsure

If yes, please explain: _____

Any supplements taken during pregnancy? Yes No Unsure

If yes, which supplements: _____

Any drugs taken during pregnancy? Yes No Unsure

If yes, please explain: _____

Any ultrasounds? Yes No Unsure

If yes, how many and at what points in pregnancy:_____

Any invasive procedures during pregnancy (i.e., Amniocentesis, ECV, etc.)? Yes No Unsure

If yes, please explain: _____

Any pets at home? Yes No

If yes, what kind(s)? _____

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Mental/Emotional Stresses – please circle appropriate response on each question & elaborate as needed

Any difficulties with lactation? Yes No Unsure If yes, what are they? _____

Any problems with bonding? Yes No Unsure If yes, what are they? _____

Any behavioral problems? ☐ Yes ☐ No If yes, what are they? _____

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare?_____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No

If no, please explain: _____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

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Informed Consent To Chiropractic Treatment

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been repeatedly demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise potential Practice Members that there are or may be some risks associated with such processes. In particular, you should note:

a) While rare, some persons have experienced rib fractures or muscle and ligament sprains or strains following manual spinal adjustments. More commonly, some persons may experience muscular soreness following adjustments. Muscles have memory and will try to return to the pre-adjusted state until they have been re-educated to the adjusted normal state. For this muscular soreness, Epsom salt soaks and/or magnesium oil/lotion/gel use is recommended after your initial visits.

b) There have been alleged cases of injury to a vertebral artery following manual cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) There have been rare reported cases of disc injuries following cervical and lumbar manual spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused, by spinal adjustment or chiropractic treatment.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as contents of this Consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care until otherwise revoked in writing.

Date:_____

Practice Member's Name: _____Witness's Name: _____

Practice Member's Signature: _____Witness's Signature: _____

Authorization For Care of a Minor (Under 18 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic. My child may be seen with / without (circle one) my presence. If you circle without, please note who else may bring your child to be checked.

Child's Name: _____ Parent's Name:_____ Date: _____

Parent's Signature:_____Witness's Signature: _____

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Office Policy of Health Revolution

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best family health care available. In return, we expect you to experience improved nervous system function. It is our experience that our practice members who follow these simple guidelines obtain the best results and greatest benefits to their health.

CLINIC HOURS Initial _____

Our day is divided into adjustment hours and assessment hours. Assessment hours include: consultations, assessments and discussion of findings with practice members. Consultations, assessments and reports should be scheduled during assessment hours only. Open adjustment hours are posted in the office and are subject to change. Since no appointment is required, we cannot tell you when it will be busy in the office or what kind of wait period there will be at any particular time. During open adjusting hours, the chiropractor may not generally be available for answering questions. An appointment is suggested if you need to discuss any concerns. Your chiropractor is Webster Technique certified and serves pregnant women. Occasionally, this may take the doctor out of the office during adjustment hours to go help a laboring mom. Pregnant women and infants under 6 months are bumped to the front of any lines in the office. Additionally, we may be closed for various reasons including holidays, continuing education seminars, and vacations. Schedule changes will be posted in the office and on our Facebook page with as much advanced notice as possible, so please follow us on Facebook at facebook.com/HealthRevolutionLindale

APPOINTMENT SCHEDULING & MISSED APPOINTMENTS Initial _____

Appointments are required only at the 1st visit due to the time needed for history review and an exam, if warranted. During orientation, we will tell you how many visits you need each week (we recommend once/week on average) and what exercises you should be doing to allow for proper care, a must for spinal and postural correction to remove nerve interference during care. Appointments are not required beginning with the 2nd visit. Orientation attendance is required to have a 3rd visit. We expect Practice Members to take responsibility for their care

CHILDREN AND FAMILY Initial _____

Once you understand that the nervous system controls and coordinates all functions of the body and subluxations interfere with nerve function, we expect that you may want everyone in your family assessed. We extend an opportunity for you to have your family checked.

FINANCIAL AGREEMENTS Initial _____

Effective 9/1/17, spinal adjustment visits are $25 each and adjustment visits where extremities are adjusted are $45. If you attend orientation and get adjusted at least 2x/month with us, you may participate in the BOX ON THE WALL. This means you set your own visit fee. We have never refused care to anyone based on (in)ability to pay.

INTERRUPTION OF CARE / COPY OF RECORDS Initial _____

In the unlikely event it becomes necessary to discontinue care for any reason, a copy of your records is available for a $10 fee. The fee is for the thumb drive that it is loaded onto.

REMEMBER Initial _____

Spinal correction and healing takes time. If you do not feel satisfied with your body's responses, please make a consultation appointment outside adjusting hours to discuss this with your doctor. We want you to obtain the most from your chiropractic care.

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PRACTICE MEMBER ORIENTATION Initial _____

We provide orientation at least twice a month. Orientation is required to be eligible for the privilege of using the BOX ON THE WALL. There is no charge for orientation and during orientation, the home exercises are demonstrated.

REFERRALS/REVIEWS Initial _____

The successes of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like to invite to our office or the orientation, please let us know. Additionally, should you have someone in another town that you feel would benefit from an assessment by a chiropractor, we would be happy to provide you with names of doctors in their area.

We appreciate your 5 star reviews of our office on Facebook, Yelp, and Google. We strive for excellence so if you do not feel that you can provide the highest rating, we would appreciate the feedback in person allowing an opportunity for improvement prior to anything being posted online.

I have read and understand the above policies and agree to abide by them.

_____ _____
Signature Date

_____ _____
Witness Date

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Probationary Practice Member Expectations

I agree to the following terms for my child's care beginning on _____, 20___ :

Initial

_____ I understand that a nonrefundable fee due on first visit includes a review of my health history, an exam if warranted, and the first adjustment visit. I understand that the fee is $25 per visit for a spinal adjustment or $45/visit with spinal plus extremity adjusting.

_____ I understand that no potential Practice Member(s) are adjusted without a completed history and spinal assessment and that if imaging is warranted, no manual adjustments will be performed until imaging has been reviewed whether it be imaging ordered at Health Revolution Lindale, PLLC or imaging completed prior to a first visit at this office.

_____ I understand we must attend an orientation session to be eligible to use the BOX ON THE WALL. I understand that if I get adjusted at least twice each month and have attended orientation, I may set my own fees for care and that receipts will not be supplied. My cancelled check from the BOX ON THE WALL will serve as my receipt

_____ I understand that Health Revolution Lindale, PLLC is out of network with all health insurance companies. I understand that the fees (mostly because YOU, the practice member set them) at Health Revolution Lindale, PLLC as detailed above are not considered reasonable or customary by insurance companies and that our services are not eligible for reimbursement, however, some Health Savings Accounts (HSA) may provide reimbursement and I understand that such reimbursement requests are my responsibility. I understand that insurance does not cover wellness or maintenance care.

_____ I agree to pay in CASH or check in person and if a check is returned for insufficient funds, I agree to pay a $35 NSF fee in CASH along with the amount the check was written for.

_____ I / We will not skip any of the recommended visits during each paid period of care.

_____ I / We agree to perform exercises assigned by Health Revolution's staff as prescribed.

_____ I / We agree to notify Health Revolution's staff of any changes to health status following first visit.

_____ I / We understand that chiropractic care is not about relief of pain but that it is about optimizing the function of my nervous system within the limitations of matter and that many have experienced the side effect of pain relief from chiropractic care. I / We understand, pain is caused by inflammation and consumption of anti-inflammatory foods like turmeric and ginger are recommended on a daily basis.

I ACCEPT / DO NOT ACCEPT the recommendations of the staff at Health Revolution Lindale, PLLC.
(circle one)

Practice Member Name (printed) _____ Date: _____

Practice Member Signature _____

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Practice Member Privacy Consent Form

For Collection, Use and Disclosure of Personal Information

We are not a covered entity subject to HIPAA because we do not file or accept any insurance, however, privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our Practice Members.

In this office, the Privacy Information Officer is:

Dr. N. LeAnne Davis, DC

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses Practice Members' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient Practice Member care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options, including which we are aware of that are available outside our office
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services
- to communicate with other treating health-care providers, including specialists and referring doctors
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of Practice Members' charts and records to governing bodies in a timely fashion
- to permit potential purchasers, practice brokers or advisors to evaluate the practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale.
- to deliver your charts and records to the office's insurance carriers to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for requested by the Texas Board of Chiropractic Examiners
- to invoice for services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law
- to verify your attendances through office sign-in sheets

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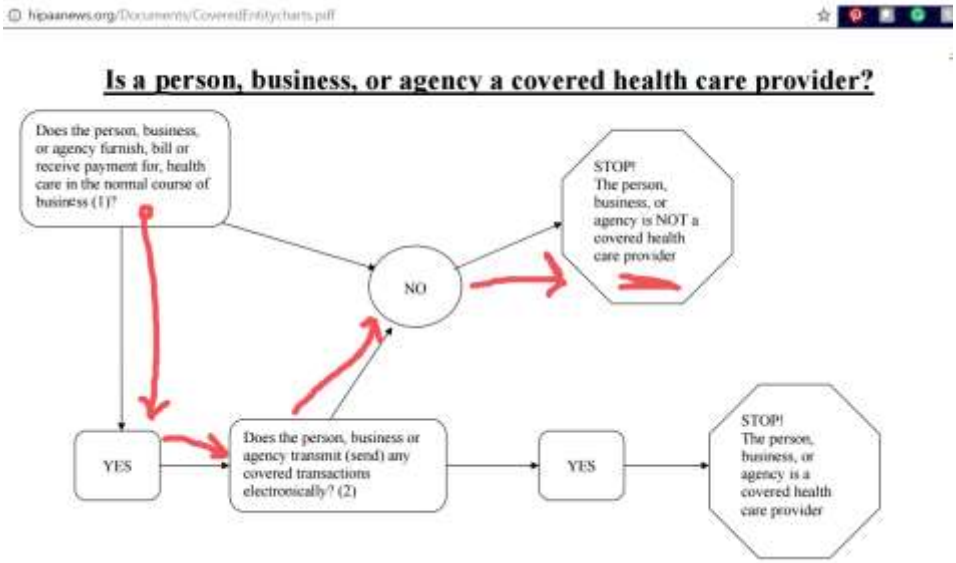
By signing the consent section of this Practice Member Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

While we are not a covered entity for compliance with the Health Insurance Portability and Accountability Act (HIPAA), we will comply with requests for records from regulatory authorities under the terms of the Health Insurance Portability and Accountability Act (HIPAA) and for the defense of a legal issue.
http://hipaanews.org/Documents/CoveredEntitycharts.pdf



Our office will not under any conditions supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process

Practice Member Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that **Health Revolution Lindale , PLLC** can collect, use and disclose personal information about the mentioned person below as set out above in the information about the office's privacy policies.

I have received a copy of the Privacy Information Sheet.

_____ _____
Signature Print Name

_____ _____
Date Signature of Witness

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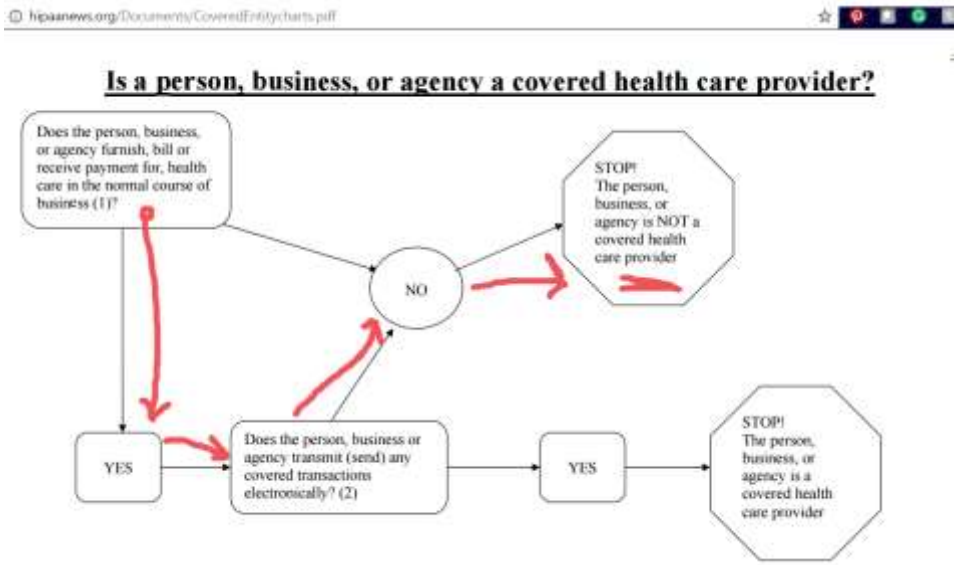
Privacy Information Sheet

How To Access the Privacy Process in Our Office

While we are not a covered entity for compliance with the Health Insurance Portability and Accountability Act (HIPAA), privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.



Our privacy information officer can be reached at:

Dr. LeAnne Davis DC
1816 S Main Suite B3, PO Box 2224
Lindale TX 75771
OFFICE: 903-882-8845, FAX: 903-881-5119
healthrevolutionlindale@gmail.com

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you do have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax or email.

Our privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Texas Board of Chiropractic Examiners. We have included all the necessary contact information listed below.

Phone: (512) 305-6700
Fax: (512) 305-6705

https://www.tbce.state.tx.us/

Our Privacy Code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

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