CONFIDENTIAL HEALTH HISTORY

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

Address: _____ Other Address: _____

City: _____ State: ____ Zip: _____ Other: City: _____ State: ____ Zip: _____

Child's Birth Date: _____ Sex: M F Parent's Birth Date: _____ Age: ____ Sex: M F

Parent's Social Security# _____-_____-_____ Patent's Driver's License #: _____State:_____

Mobile # _____ Second Mobile # _____ E-mail:_____

Case of An Emergency Contact: _____ Phone #_____

Who Referred You to Our Office: _____

Would you like "<u>APPOINTMENT REMINDERS</u>" For Scheduled Appointments: Yes - ☐ No - ☐

DESCRIBE YOUR COMPLAINTS

Describe Your Child's Chief Complaint: _____

_____

_____

_____

_____

_____

Was The Child Born In The Hospital Or At Home? _(Details:)_____

_____

_____

_____

<u>At Birth:</u> **<u>Today:</u>**

Height: _____ Weight: _____ **Height: _____ Weight: _____**

When Did This Condition Begin? _____

How Did This Condition Begin? _____

What Makes This Complaint Worse?_____

What Have <u>You</u> Done To Help Your Child's Complaint? _____

_____

Has This Condition Ever Occurred Before? NO , YES - When_____ How many Other times?_____

Other Doctors You Have Seen For This Condition:_____

*** What Other Complaints Does The Child Suffer From? _____**

_____

Does the Child Have Siblings: (List w/Ages): _____

UNDERSTANDING "CHIROPRACTIC CARE"

Chiropractic care is a drugless form of health care that focuses on reducing abnormal irritation to your body / nerves by normalizing the motion of your spinal joints. This type of care has been used for over 100 years and has been helpful in reducing pain while promoting your bodies ability to heal itself. Doctors of Chiropractic are trained at Chiropractic Colleges and are licensed by the state to perform this care. Using these conservative drug free principles, Chiropractic Care continues to grow and we are happy you chose our office to begin your quest for better health.

CONSENT TO EXAM / TREATMENT / HIPAA POLICY

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The practice of chiropractic involves the doctor to conduct a physical exam and to physically touch the body. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Although doctors of Chiropractic are experts in chiropractic diagnosis, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases unknown underlying physical defects, deformities or pathologies may increase the patient susceptible to injury. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. Some of the risk of treatment could result in bruising of the skin, pain in the muscles and joints, strains/sprains of the joints, joint dislocation, bone fractures, disc injuries and in rare circumstance neurological injuries and/or strokes.

We will do everything possible to reduce the chances of these risks but your permission is necessary to begin care.

I hereby request and consent to have Dr. Curtis Dearmont, DC perform a physical examination and perform treatment which may include spinal and soft tissue manipulations to help improve my complaints. I understand and am informed that, as in the practice of medicine and Chiropractic, there are some risks to all treatments. I do not expect the doctor(s) to be able to anticipate all these risks and complications, and I will rely on the doctor(s) to exercise their professional judgment during the course of my care concerning which treatment(s) are in my best interest, based upon the facts as they known.

***X*_____ *DATE:* _____**

Parent's Signature to Consent to Care For a Child:

Acknowledgement of Receipt of Notice of Privacy Practices: CHIROPRACTIC HEALTHCARE CENTER USES PERSONAL INFORMATION ONLY AS RELATED TO PROVIDING CARE AND BILLING PURPOSES IN ACCORDANCE WITH STATE AND FEDERAL PRIVACY GUIDELINES. WE DO NOT SHARE YOUR INFORMATION BEYOND WHAT IS REQUIRED FOR THESE PURPOSES.

I acknowledge that I may request a copy of the Notice of Privacy Practices or I have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

***X*_____ *DATE:* _____**

Parent's Signature to HIPAA Policy: