PEDIATRIC APPLICATION FOR CARE
COLUMBIA FAMILY CHIROPRACTIC

Today's Date: _____/_____/____

PATIENT DEMOGRAPHICS

HR#:_____

Childs Name:_____

Date of Birth: _____/_____/_____ Age: _____ Email:_____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (Home): _____

Mother's Name: _____ DOB:_____/_____/_____ Mother's Mobile: _____

Father's Name: _____ DOB:_____/_____/_____ Father's Mobile: _____

Pediatrician/Family MD: _____City/State: _____

Last Visit: _____/_____/_____ Reason for visit:_____

Who is responsible for this bill? _____

Primary Insurance:_____ Policy Number:_____

Policy Holder Name:_____ Policy Holder DOB: _____

Secondary Insurance:_____ Policy Number:_____

Policy Holder Name:_____Policy Holder DOB: _____

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

Has this problem occurred before? _____ Yes _____No If yes, when?

_____

Any bowel or bladder problems since this problem began?: If yes, please describe:

_____

Have you seen any other doctors for this problem? ___Yes ___No If yes, who and when?

_____

How is this problem NOW?: □ Rapidly Improving □ Improving Slowly □ About the Same

□ Gradually Worsening □ On & Off

Please list any medication currently taken: _____

_____

Has your child ever sustained an injury playing organized sports? _____ Yes _____ No If yes; please explain:

_____

_____

_____

Has your child ever sustained an injury in an auto accident? _____ Yes _____ No 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 Columbia Family 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

_____ _____

Doctor's Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache			Neck			Low Back			
No pain										**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**

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1 – What is your pain RIGHT NOW?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

2 – What is your TYPICAL or AVERAGE pain?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Columbia Family Chiropractic's Office Policy

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your child's personal health information. In addition, we must provide you with written notice concerning your rights to gain access to your child's health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about your child 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. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

- Treatment purposes: Discussion with other health care providers involved in your child's care.
- Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you and your child in a private consultation room.
- For payment purposes: To obtain payment from your insurance company or any other collateral source.
- For workers compensation purposes: To process a claim or aid in investigation.
- Emergency: In the event of a medical emergency we may notify a family member.
- For public health and safety: In order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
- To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
- For military, national security, prisoner and government benefits purposes.
- Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
- Telephone calls or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
- Change of ownership: In the event this practice is sold the new owners would have access to your PHI

YOU/YOUR CHILD'S RIGHTS:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive detailed privacy notice
- To request mailings to an address different than residence
- 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.
- To inspect your child's records and receive one copy of your child's records at no charge, with notice in advance
- To request amendments to information, however like restrictions we are not required to agree to them.
- To obtain one copy of your child's 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.

I understand my child's rights as well as the practice's duty to protect my child's 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 any time in the future and will make the new provisions effective for all information that it maintains past and present. If you wish to make a formal complaint about how we handle your child's health information, please call the office at (803) 788-8831.

I am aware that a more comprehensive version of this notice is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my child's rights or any of the information I have received.

_____ _____

Patient Name (print) **Patient DOB**

☐

Witness Initial

_____ _____

Parent or Legal Guardian Signature **Date**

Columbia Family Chiropractic's Office Policy

As a potential new patient, it is important that you understand our office policies regarding how patients of this practice are cared for. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read 'Our Office Policies', if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your child's ***Application for Treatment,*** please let our receptionist know and a member of our staff will be happy to discuss them with you further. It is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic care. Since the majority of 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 reaps 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 child's life.

□ **PATIENT PRIVACY –** Since the majority of 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 other 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 with the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CHILD'S 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 **Columbia Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. 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 your child beyond simple pain relief, through two distinct phases of care to make a structural correction to your child's spine that will enable their central nervous system to function optimally, thereby improving their 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 child's condition and exact location of subluxations. The results of these procedures will aid in assessing your child's presented problem, overall health and, in particular, the condition of your child's spine. It will also assist the doctor in determining the type and amount of care your child 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 child's 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 child's health, immediately following their first adjustment, they 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 child's case, therefore attendance is required for individuals who wished to become new patients of this practice. Because the results of their x-rays, all examinations, and the doctors' recommendations for care will be discussed at that time, we strongly urge any and all guardians to be present. We know from experience that when a patient's family understands the goals and objectives of chiropractic care, they become supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices "Office Policies", the first page of which I have read and retained. This 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 Name (print) **Patient DOB** **Witness Initial**

_____ _____

Parent or Legal Guardian Signature **Date**

INFORMED CONSENT

REGARDING: Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important for each patient and their guardian to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

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

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

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 spinal examination, we encounter non-chiropractic or unusual findings, we will alert you of the findings. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the 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 OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxation.

Treatment objectives and the risks associated with chiropractic adjustments and all other procedures provided at Columbia Family Chiropractic have sufficiently been explained to me, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to a full examination and treatment of my child by any means, method, and or techniques the doctor deems necessary to determine and treat my child's condition at any time throughout the entire clinical course of their care.

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 child's case.

I hereby authorize payment to be made directly to Columbia Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Columbia Family Chiropractic for any and all services my child receives at this office.

_____	_____	☐
Print Name	**DOB**	
_____	_____	**Witness Initial**
Parent or Legal Guardian Signature	**Date**	

FEMALES ONLY: Please read carefully, and check the boxes, include the appropriate date, then sign above if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on: ____/____/____

☐ I have been provided a full explanation of when my child is mostly likely to become pregnant, and to the best of my knowledge, my child is not pregnant.