PEDIATRIC APPLICATION FOR CARE
COLUMBIA FAMILY CHIROPRACTIC

WELCOME TO OUR PRACTICE!

Today's Date: ___________________ ***Who can we thank for referring your child to this office? ________________________________***

PATIENT DEMOGRAPHIC

Child's Name: ____________________________________ Birth Date: _____-_____-_____ Age: _________ ❑ Male ❑ Female

Height: _______________ Weight: _________________

Address: ____ City: _________________________________ State: _____ Zip: ___________

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

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

Parent/Guardian Social Security Number: ____________________________ Email Address: _____________________________________

BILLING/INSURANCE INFORMATION

Who is responsible for this bill? _____________________________ Payment Method: ❑Self Pay ❑Insurance

Primary Insurance: _______________________________________ Policy Number: ____

Policy Holder Name: ______________________________________ Policy Holder DOB: _______________________________________

Secondary Insurance: _____________________________________ Policy Number: ____

Policy Holder Name: ______________________________________ Policy Holder DOB: _______________________________________

HISTORY OF COMPLAINT

Purpose of this visit: ❑ Wellness Check-up ❑ Injury or Accident ❑ Other ______________________________

Describe: ____

If your child is currently experiencing pain/discomfort, please explain where and for how long: ________________________________

When did the problem first begin? __________________ Onset: ❑ Gradual ❑ Sudden

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?: ❑ Improving Rapidly ❑ Improving Slowly ❑ Worsening Gradually ❑ Worsening Rapidly ❑ About the Same ❑ Comes and Goes

PAST HISTORY

Birth and Delivery:

Type of delivery: ❑ Vaginal -unassisted ❑ Vaginal -assisted ❑ Vaginal after cesarean (VBAC) ❑ Cesarean

Devices used: ❑ Forceps ❑ Vacuum ❑ None

Problems during pregnancy/labor: ____

Congenital abnormalities noted at birth: ____

Infant Years:

Infant feeding: ❑ Breastmilk ❑ Formula ❑ Combination of both

If mother desires/desired to breast feed and was unable, describe difficulties: ____

Complications: ❑ Colic ❑ Reflux ❑ Tongue/Lip Tie ❑ Torticollis ❑ Diarrhea ❑ Constipation

Delayed or skipped developmental milestones: ____

Childhood Years:
Check all that apply

❑ Headaches	❑ Asthma	❑ Diarrhea	❑ Backaches	❑ Bed wetting
❑ Dizziness	❑ Eczema	❑ Constipation	❑ Neckaches	❑ Sleeping Problems
❑ Fainting	❑ Chronic Earaches	❑ Ruptures/Hernia	❑ Joint pain	❑ ADD/ADHD
❑ Seizures/Convulsions	❑ Sinus Infections	❑ Reflux	❑ Broken Bones	❑ Behavioral Problems
❑ Heart Issues	❑ Feeding Issues	❑ Muscle Pain	❑ Scoliosis	❑ Sensory issues
❑ Anemia	❑ Poor Appetite	❑ Growing Pains	❑ Poor posture	❑ Other: ____________
❑ Respiratory Issues	❑ Stomach Aches	❑ Trouble Walking	❑ Falls: __________	❑ Other: ____________

❑ Allergies: ____

❑ Any sports child plays: ____

Please list any prescription medications or supplements your child is taking: ____

Please list any past surgeries/procedures: ____

Pediatrician/Family MD: ____City/State: ____

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

Immunization History: ____

Number of doses of antibiotics your child has taken. Past 6 months: _________________ During his/her lifetime: ______________________

Previous chiropractor: ___________________________________ Date of last visit: ______________________________

FAMILY HISTORY

Some health issues are hereditary. Tell us about the health of your child's immediate family members:

Relative	Age (If Living):	State of Health: Good	Poor	Illnesses:	Age at Death:	Cause of Death: Natural	Illness
Mother		❑	❑			❑	❑
Father		❑	❑			❑	❑
Brother		❑	❑			❑	❑
Sister		❑	❑			❑	❑

ACKNOWLEDGEMENTS

Please read each statement and initial your agreement:

_______ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help in the restoration of my child's health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_______ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives. I 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.

_______ To the best of my ability, the information I have supplied above is complete and truthful. I have not misrepresented the presence, severity, or cause of my child's health concern.

____ ________________________

Parent or Legal Guardian Signature **Date Completed**

____ ________________________

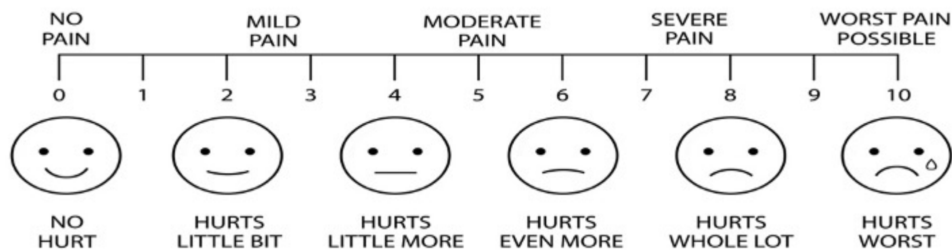
Doctor Signature **Date Form Reviewed**

Witness Initial ☐

Pediatric Quadruple Visual Analogue Scale

Instructions: Please circle the number that is most appropriate for your child.
If your child is having pain in more than one location, please answer each question for each individual complaint area.

The pediatric pain measurement scale can be used with participatory children to gauge how they view their pain. This may be helpful as you determine scoring.



Primary Complaint: ____

1 – Rate your pain RIGHT NOW
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2 – Rate your TYPICAL OR AVERAGE pain
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3 – Rate your pain AT ITS WORST (How close to a "10" does your pain get?)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4 – Rate your pain AT ITS BEST (How close to a "0" does your pain get?)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Secondary Complaint: ____

1 – Rate your pain RIGHT NOW
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2 – Rate your TYPICAL OR AVERAGE pain
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3 – Rate your pain AT ITS WORST (How close to a "10" does your pain get?)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4 – Rate your pain AT ITS BEST (How close to a "0" does your pain get?)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Comments/Notes: ____

____

This form is an adaptation of "Quadruple Visual Analogue Scale" reprinted from Spine, 18, Von Korff M, Reyo 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 Notice of Privacy Practices

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. **Please keep this page for your records.**

PERMITTED DISCLOSURES:

- **Treatment Purposes**: Discussion with other health care providers involved in your child's care.
- **Payment Purposes**: Use and share your child's health information to bill and get payment from insurance providers, health plans, or other entitles.
- **Phone Calls/Emails and Appointment Reminders**: Call/email you and leave messages regarding a missed appointment or to update you of changes in practice hours or upcoming events.
- **Inadvertent Disclosures**: Open treatment areas mean open discussion, if you need to speak privately to the doctor, please let our staff know so we can place you and/or your child in a private consultation room.
- **Workers Compensation Purposes**: To process a claim or aid in an investigation.
- **Respond to Lawsuits and Legal Actions**: Share health information about your child in response to a court or administrative order, or in response to a subpoena.
- **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.
- **Government Agencies or Law Enforcement:** To share information about your child if state or federal laws require it. Additionally, to identify or locate a suspect, fugitive, material witness or missing person.
- **For Military, National Security, Prisoner and Government Benefits Purposes.**
- **Emergency:** In the event of a medical emergency, we may notify a family member.
- **Deceased Persons:** For discussion with coroners and medical examiners in the event of a patient's death.
- **Change of Ownership:** In the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

- To receive a paper copy of the comprehensive detailed privacy notice
- To receive an accounting of disclosures
- 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 or obtain a copy of your child's medical records or x-rays, usually within 30 days of your request. We may charge a reasonable, cost-based fee for copies of records and/or x-rays.
- To request amendments to information; however, like restrictions, we are not required to agree to them.
- To choose someone to act for you. If you have given someone medical power of attorney or someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- To file a complaint if you feel your rights are violated.

I understand my 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 health information, please call the office at (803) 888-6646.

I am aware that a more comprehensive version of this notice is available to me and can be requested at any time. At this time, I do not have any questions regarding my child's rights or any of the information I have received.

______________________________________	________________________
Parent or Legal Guardian Name (Print)	**Date Completed**
______________________________________	________________________
Parent or Legal Guardian Signature	**Date Form Reviewed**

Witness Initial ☐

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, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you and your child 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, please let our receptionist know and a member of our staff will be happy to discuss them with you further. We believe 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. 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 reap 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 life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you or your child has with the doctor may 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 patients during treating hours while patients are being adjusted. If you have a confidential matter you or your child wish to discuss, please let us know and we will schedule time for you to speak to 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. Your doctor will outline a course of treatment **specific to your child** that will take them beyond simple pain relief. Through two distinct phases of care, our goal is to make structural correction to the spine that will enable the central nervous system to function optimally, thereby improving 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 condition and location of subluxations. The results of these procedures will aid in assessing your child's presenting problem, overall health and, in particular, the condition of the spine. They 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, you 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 wish to become new patients of this practice. Because the results of your child's examination and x-rays as well as the doctors' recommendations for care will be discussed at that time, **we strongly encourage all guardian be present**. We know from experience that when a patient's family understands the goals and objectives of chiropractic care, and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices "Office Policies". This page 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.

____ _________________________

Parent or Legal Guardian Name (Print) **Date Completed**

____ _________________________

Parent or Legal Guardian Signature **Date Form Reviewed**

Witness Initial ☐

INFORMED CONSENT

REGARDING: Exam, Chiropractic Adjustments, and Therapeutic Procedures

The nature of the chiropractic adjustment:

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat your child. We may use our hands or a mechanical instrument upon your child's body in such a way as to move their joints. This may cause an audible "pop" or "click." They may feel a sense of movement.

Analysis / Examination / Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- radiographic studies
- Other (please explain:)____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. We will make every reasonable effort during consultation, examination, and X-ray to screen for contraindications to care; however, if your child has a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The availability and nature of other treatment options:

Other treatment options for your child's condition may include: Self-administered, over-the-counter analgesics and rest; medical care and prescriptions such as anti-inflammatories, muscle relaxants, and pain relievers; hospitalization; and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your child's pediatrician or primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may worsen condition, reduce mobility, or increase pain. Over time this may complicate treatment making it more difficult and less effective.

Incidental findings:

If during the course of 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 a health care provider who specializes in that area.

REGARDING: X-rays/Imaging Studies

During your child's examination, the doctor may feel that x-rays will be needed in order to provide treatment. In order to perform x-rays on any patient, our office requires that patients consent for such tests to be performed.

FEMALES ONLY: Please read carefully and complete below:

□ First day of child's last menstrual cycle was on ____/____/____ □ To the best of my knowledge, my child is not pregnant

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE:

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Columbia Family Chiropractic have been explained to me to my satisfaction.

I acknowledge 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 do hereby consent to a full examination and treatment 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 care.

____ ________________________

Parent or Legal Guardian Name (Print) **Date Completed**

____ ________________________

Parent or Legal Guardian Signature **Date Form Reviewed**

Witness Initial [ ]

HIPAA Personal Health Information Release Authorization

Communication with Others:

I, ______________________________, hereby authorize Columbia Family Chiropractic to discuss with and/or release information to the following people concerning my child's appointments, insurance, billing, and health treatment rendered.

- ❑ Parent/Legal Guardian
- ❑ Other Specified Person: ______________________________
- ❑ Information is not to be discussed with or released to anyone

Restrictions:

- ❑ No Restriction
- ❑ Only discuss my appointment time with the above-named individual(s).
- ❑ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ❑ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

I authorize Columbia Family Chiropractic to call, text, email me regarding:

- Appointment Reminders/Scheduling
- Information Regarding Insurance/Billing
- Upcoming Events/Workshops
- Requests for Patient Satisfaction Online Reviews

I authorize such messages to be delivered to the following:

Preferred phone number: ____

Preferred email address: ____

I understand and acknowledge that electronic communication carries certain risks, including but not limited to unauthorized access, potential breaches of privacy, and transmission errors. Despite these risks, I wish to communicate with Columbia Family Chiropractic electronically for matters related to my medical care and records.

I acknowledge that Columbia Family Chiropractic will take reasonable precautions to protect the security and confidentiality of the information sent electronically, including using secure email systems and encryption where possible. However, I understand that Columbia Family Chiropractic cannot guarantee the absolute security of electronic communication.

I acknowledge I am responsible for providing the practice with any updates to my email address and/or phone number.

I understand I may terminate this consent at any time by giving written notice to Columbia Family Chiropractic.

______________________________________ ________________________

Parent or Legal Guardian Name (Print) **Date Completed**

______________________________________ ________________________

Parent or Legal Guardian Signature **Date Form Reviewed**

Witness Initial ☐