"Natural family wellness care"

Sonak Family Chiropractic
www.drwill.net

Pediatric Entrance Form

Patient's Full Name:_____ Nickname:_____

Address:_____ City:_____

City:_____ State:_____ Zip:_____

Birth Date:____/____/____ Sex: □Male □Female Weight:_____ Height:_____

Names of Parents/Guardians:_____

Parent's/Guardian's phone:_____

Parent's/Guardian's email:_____

Purpose For Contacting Us?_____

Other Doctors seen for this condition_____

Referred By:_____

Check any of the Following Conditions Your Child has suffered from during the past 6 months:

□ Ear Infections	□ Scoliosis	□ Seizures	□Chronic Colds
□ Headaches	□Asthma/Allergies	□Digestive Problems	□ ADHD
□Recurring Fever	□ Growing/Back Pains	□Colic	□ Bed Wetting
□ Car Accident	□ Temper Tantrums		

Family Medical History:_____
Previous Chiropractor:_____
Name of Pediatrician:_____

Number of Antibiotics Your Child Has Taken
During the past 6 months_____, Total during his/her Lifetime:_____

Number of Doses of Other Prescription Medications your child has taken:
During the Past 6 months:_____, Total during his/her Lifetime:_____
List:_____
_____
Vaccination History:_____

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PRENATAL History:
Name of Obstetrician/Midwife:_____
Complications During Pregnancy? ___N____Y List:_____
Ultrasounds During Pregnancy? ____N ____Y Number:_____
Medications During Pregnancy/Delivery? ____N____Y List:_____
Cigarette/Alcohol Use During Pregnancy _____N_____Y
Location of Birth: _____Hospital _____Birthing Center _____Home
Birth Intervention: ___ Forceps _____Vacuum Extraction ____Caesarian Section, Emergency or Planned?
Complications During Delivery ? _____N _____ Y, List _____
Genetic Disorders or Disabilities: ____N _____Y List:_____
Birth Weight_____ Birth Length_____

FEEDING History
Breast Fed:____N ___Y, How Long?_____
Formula Fed: ____N ____Y, How Long?
Introduced to Solids at:_____ Months, Cow's Milk at _____ Months
Food Allergies or Intolerances:_____

DEVELOPMENTAL History:
* According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. A bed, changing table, down stairs etc.) Was this the case with your child? ____Y_____N
* Has your child been involved in any high impact or contact type sports (i.e. soccer, football gymnastics)___Y___N
* Has your child ever been involved in a Car Accident? _____N_____Y
* Has your child ever been seen on an Emergency Basis _____N_____Y List:_____
* Other Traumas not described?? List:_____

Child Hood Disease (please check any that apply)
□ chicken pox □ mumps □ rubella □ whooping cough
□ Other_____

AUTHORIZATION FOR CARE OF MINOR

I HEARBY AUTHORIZE THIS OFFICE AND ITS DOCTOR TO ADMINISTER CARE OF MY SON/DAUGHTER AS THEY DEEM NECESSARY, I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENTS OF ALL FEES AND CHARGES BY THIS OFFICE.

SIGNED:_____ DATE:_____

SIGNED BY:_____

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HIPPA Privacy

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Sonak Family Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Sonak Family Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Print Name:_____

Guardian's Signature: _____ Date: _____

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TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any 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 adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 a chiropractic spinal evaluation, 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 a 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)

I have been informed of my condition and give consent to treat. I have been informed of possible outcomes including any risks that may occur. Any questions you may have will be answered by our office.

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 on this basis.

_____ _____
(signature) (date)