Patient #_____

Case History for Children

Child's Name _____ Date _____

Social Security #_____ Sex ☐ Male ☐ Female

Child's Date of Birth _____ Age _____ Weight _____

Mother _____ Father _____

Address _____ City_____ State ____ Zip _____

Home Phone _____ Cell _____

Email Address _____

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

If yes, when and by whom? _____

Referred By_____

What brought you to our office?

☐ Wellness Care/ Check-Up

☐ Help !!

Main Complaint & Symptoms

Main Problem _____

Pains/Complaints are ☐ Dull ☐ Sharp ☐ Burning ☐ Numb

Frequency ☐ Constant ☐ Intermittent

Date it began _____

What makes condition better? _____

What makes condition worse? _____

Birth through Age 13

Birth Process

YES	NO		Comments
		Was the delivery difficult?	
		Were forceps used?	
		Was the birth by C-Section?	
		Was the baby breech?	
		Home Birth?	
		Hospital Birth?	
		Were you given drugs during delivery?	
		Was an epidural given?	
		If yes, how many times was the needle inserted before it took effect?	
		Was labor induced?	
		Were there any complications?	
		If yes, explain:	
		Has your child been under antibiotic therapy?	
		If yes, how many times?	

Growth and Development

YES	NO		Comments
		Has your child rolled out of bed?	
		Does your child sleep well at night?	
		Does your child wet the bed?	
		Does your child bang his/her head against things?	
		Does your child have asthma?	
		Does your child have allergies?	
		Does your child have ear infections?	
		Does your child have tubes in his/her ears?	

Medications

Please list any medications your child is taking:

_____

_____

Vitamins/Herbs/Minerals:

_____

_____

Medical allergies:

_____

_____

Insurance Information

Insurance Co. _____ Subscriber Name _____

Relationship to patient _____ Subscriber Birth Date _____

Subscriber Social Security # _____

Subscriber Address _____

Consent to Treatment of Minor Child

I hereby authorize Dr. Marcus Deaver, D.C. and whomever he may designate as his assistants to administer treatment, as he so deems necessary to my

_____, _____.
(Son/Daughter) (Child's Name)

Dated this _____ day of _____, 20_____

Signed: _____

Printed Name: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to 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 Patient Health Information 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 this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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 affect 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 this office 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.

Guardian's Signature: _____ **Date**: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Art of Life Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Guardian's Signature: _____ **Date**: _____