CHIROPRACTIC CENTER OF GLASTONBURY

Children's Health History

Dr. Patrick J. DeFrancesco
Chiropractor

Name _____ Date _____

Parents/Guardians _____

Address _____ City/State _____ Zip _____

Home Phone _____ Parent Work Phone/s _____

Birthdate _____ Other Children - Names/Ages _____

_____

Who referred you to us? _____

Past Chiropractic care? Yes / No Dr.'s name/location _____

_____ Last Visit _____

Current Medical Care? Yes / No Why? _____

Current Drugs / Medication _____

_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES CURRENT GOALS FOR YOUR CHILD'S HEALTH / WELL BEING.

- ❑ **I am only concerned about relief of a particular symptom.**
- ❑ **I am only concerned about relief of a particular symptom, and preventing its return.**
- ❑ **I want optimum health and well being on every level for my child.**

WE ACCEPT PAYMENT BY CASH, CHECK and CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature _____ **Date** _____

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Personal History

THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION NORMALLY. HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURAL ABILITY.

THIS INTERFERENCE IS MOST COMMONLY THE RESULT OF VERTEBRAL SUBLUXATIONS.

STRESS THAT MAY BE PHYSICAL, CHEMICAL OR EMOTIONAL MAY CAUSE THESE SUBLUXATIONS.

THE PRACTICE OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE SYSTEM INTERFERENCE CAUSED BY THE VERTEBRAL SUBLUXATION.

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH BIRTH:

(PLEASE CIRCLE ANY THAT APPLY)

During Pregnancy

1) Drugs / medicine
2) Tobacco / alcohol
3) Illness during

Explain_____

_____

_____

During Labor & Delivery

1) Labor chemically induced?
2) Labor doctor assisted?
3) C-section delivery?
4) Forceps/vacuum extraction?
5) Doctor pull or twist baby?
6) Premature delivery?

Explain_____

_____

_____

Since Birth

1) Nursed how long? _____
2) Baby jaundiced?
3) Feeding problems?
4) Sleeping problems?
5) Colic?
6) Vaccinations?

Explain_____

_____

_____

_____

_____

_____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

1) Any falls or injuries?
2) Respiratory problems?
3) Ear infections?
4) Allergy / Asthma?
5) Bedwetting?
6) Digestive problems?
7) Hyperactivity?
8) Other health problems?
9) Hospitalized?

Explain _____

_____

_____

_____

_____

_____

_____

ANYTHING ELSE?_____

_____

_____

I hereby authorize the above named doctor(s) and whoever may be designated as assistants; to provide chiropractic care as may be deemed necessary to my child / ward.

Signature:_____

HEALTH CONDITIONS

Please check each of the diseases or conditions you have now or have had in the past.

- ❑ Dizziness
- ❑ Headache
- ❑ Neck pain
- ❑ Numbness in arms/legs/hands
- ❑ Lower back pain
- ❑ Pain in arms/legs/hands
- ❑ HIV/AIDS
- ❑ Joint replacement _____
- ❑ Heart surgery/pacemaker
- ❑ Heart attack/stroke
- ❑ High/Low blood pressure
- ❑ Arthritis
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Cancer/Chemotherapy

Are you pregnant? ❑ Y ❑ N

Are you taking birth control pills? ❑ Y ❑ N

Date of last menstrual cycle: _____

❑ Other(s): _____

❑ Please list surgeries and dates: _____

_____

_____

_____

_____

DEMOGRAPHICS

Preferred Language: _____

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / Caucasian / Native Hawaiian or Pacific Islander / Decline to Answer

Other: _____

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Do you smoke?

- ❑ Never
- ❑ Past
- ❑ Present:
  - ❑ Occasionally ❑ Daily

Are you taking any medications? ❑ Yes ❑ No

Medication	Dosage

Are you allergic to any medications? ❑ Yes ❑ No

Medication	Reaction	Onset Date	Comments

FOR OFFICE USE ONLY

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Would you like to receive a clinical summary after each visit? Due to the nature of chiropractic care, the clinical summaries are often blank. where you would like to receive one, we can provide it to you upon request.

Signature: _____ Date: _____ ❑ No ❑ Yes, If requested

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health insurance information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.
- Comments about your symptoms and/or progress may be discussed at your office visits.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures

You have the right to request that we do not disclose health information to certain individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information please let us know in writing. We are not required to agree to your restrictions.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing.

I have read your consent policy and agree to its terms. Initial _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will perform an examination and x-rays, if necessary, to determine a diagnosis and make treatment recommendations. If treatment is initiated, the doctor will use his/her hands in any attempt to restore normal function to your joints and muscles. Various ancillary procedures, cold packs, or other soft tissue techniques may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare complications could include muscle strain, ligamentous sprain, injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice stiffness or soreness with the first few treatments.

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers or other side effects in a significant number of cases.
- Medical care prescription anti-inflammatory drugs, muscle relaxers and analgesics. Risks of these drugs include the above mentioned side effects and patient dependence on narcotics.
- Surgery, in conjunction with medical care, adds the risks of adverse reaction to anesthesia, death, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite probable that a delay of treatment will complicate your condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Initial _____

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____