# PEDIATRIC FORM

Please fill out this form as completely and accurately as possible. All information requested below is necessary for us to serve your child with the best possible care.
If you suspect your child to have a neurosensory disorder (ADD/ADHD, autism spectrum disorder, sensory processing disorder, learning disability, etc.) or if they have been diagnosed with any of these, please fill out our neurosensory form instead.

Today's Date_____ (mm/dd/yy)

## ABOUT THE CHILD

Name_____
Birth Date_____/_____/_____ (mm/dd/yy) Age_____ Gender □M □F
Height_____ Weight_____
Address_____ City_____ State_____ Zip
Parent/Legal Guardian_____ Phone ( )_____
Occupation _____
Employer _____ SS# (opt'l) _____-____-_____
Email_____
Whom may we thank for referring you to our office?
_____

## PURPOSE OF VISIT

Describe the purpose of this visit:
_____
_____
_____
Is the purpose of this visit related to:
□ sports □ auto □ fall □ home injury □ chronic discomfort
□ other _____
Explain_____
When did this condition begin?_____
Has this condition:
□ become worse □ stayed constant □ comes and goes
Does this condition interfere with:
□ sleep □ daily routine □ other activities
Explain:
_____
_____
Has this condition ever occurred before? □Y □N
Explain:
_____
_____

Have you seen other doctors for this condition? □Y □N
Dr.'s Name(s)

_____

Type of Treatment

_____

Results_____

_____

## MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:
.....take any medication? □Y □N If yes, explain:_____
.....smoke or consume alcohol? □Y □N
.....experience any illness? □Y □N If yes, explain:_____

Approximately how long did labor last? _____hours
Was labor chemically induced? □Y □N
Was labor doctor assisted? □Y□N
Was a C-section performed? □Y □N
Were forceps or vacuum extraction used? □Y □N
Did the delivery doctor pull or twist the baby during delivery? □Y □N □ unsure

Was the delivery premature? □Y □N
If yes, at _____weeks, weight_____lbs____oz

Check any of the following if the child experienced it immediately after birth:
□ jaundice □ respiratory problems
□ feeding problems □ displaced or broken joints
□ other condition(s)
Explain:

_____

## CHILD'S HEALTH HISTORY

Please check each of the following the child has now or has had in the past. While they may seem unrelated to the purpose of the visit, they can affect the overall diagnosis and course of care.

| | | |
|---|---|---|
| □ vision problems | □ pink eye | □ headaches |
| □ hyperactivity | □ constipation | □ bed wetting |
| □ frequent colds | □ ear problems | □ sleeping disorders |
| □ tubes in the ears | □ irritability | □ allergies |
| □ colic | □ breathing problems | □ digestive problems |
| □ asthma | □ attention problems | □ skin problems |

□ other_____

## VACCINATIONS

Please check which of the following statements best describes your child and vaccinations.

□ I have chosen not to vaccinate my child.

□ My child is partially vaccinated.

□ My child has received all vaccinations on the medical vaccine schedule.

Any noted side effects or reactions?

_____

## CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? □Y □N □ unsure

Has your child ever:

.....been hospitalized? □Y□N

.....had a severe fall? □Y□N

.....been in a car accident? □Y □N

Has your child ever taken antibiotics? □Y □N

If yes, explain for what condition(s) and for how long:

_____

_____

Does your child have difficulty interacting with schoolmates or friends? □Y □N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits a rocking behavior? □Y □N

What improvements (if any) in your child's health or behavior would you like to accomplish?

_____

_____

## GOALS FOR MY CHILD'S CARE

Children are seen by chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain, and others for corrections of malfunctions in their bodies. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- □ RELIEF CARE – Symptomatic relief of pain or discomfort
- □ CORRECTIVE CARE – Correcting and relieving the cause of the problem as well as the symptoms.
- □ COMPREHENSIVE CARE – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
- □ I wish the doctor to select the type of care appropriate for my child.

9209 West 110th Building #36
Overland Park, Kansas 66210
(913)322-0251

# Consent and Authorization Form

**Consent to Professional Treatment**: The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, please sign the "Consent to Treatment of Minor" section below.

If this visit and subsequent visits are for chiropractic care, the following applies: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me(or the patient for whom I am legally responsible) by the doctors of chiropractic in this clinic, or any others working at this office.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise such judgement during the course of the procedure, which the doctor feels at the time, based on the fact then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and I agree to the above named procedures. I intend this consent to cover the entire course of treatment of my present condition and for my future condition(s) for which I seek treatment.

Name(Print):_____ Name(Signature):_____ Date:_____

**Consent to Treatment of a Minor (If applicable):** I hereby request and authorize _____, and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory, and other testing at the doctor's discretion.

Child's name_____ Relationship to child:_____

As of today's date, I have the legal right to select and authorize health care service for the minor child names above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Name(Print):_____ Name(Signature):_____ Date:_____

**Consent to Perform and Interpret X-rays:** The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Name(Print):_____ Name(Signature):_____ Date:_____

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# Consent and Authorization Form (cont.)

**Assignment of Benefits and Release of Records:** The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Name(Print):_____ Name(Signature):_____ Date:_____

**Financial Obligation and Appointment Policy:** The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services rendered at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

This clinic reserves the right to charge interest on any accounts 90 days past due.

Name(Print):_____ Name(Signature):_____ Date:_____

**Patient Health Information(PHI) and Privacy Policy:** The patient consents to the use or disclosure of my protected health information by this office for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that analysis, diagnosis or treatment of me by this office may be conditioned upon my consent as evidenced by my signature below. Our Privacy Policy is not limited to, but includes the following:

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Name(Print):_____ Name(Signature):_____ Date:_____

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# Consent and Authorization Form (cont.)

**Patient Photo Release:** I hereby give permission to Align, LLC to use photographs taken of myself and/or the undersigned minor children. Photos may be used for print, web or digital reproduction and for commercial and/or editorial use, including (but not limited to) advertising/promotion via social media, e-news letters, and/or printed material relevant to Align, LLC. I seek no compensation for the use of these photographs.

I release Align, LLC from any expectation of confidentiality for myself and/or the undersigned minor children and attest that I am the parent or legal guardian of the children listed below and I have the authority to authorize Align, LLC to use their photographs and names.

Street Address: _____

City, State, and Zip: _____

Names and Ages of Minor Children:

| | | | |
|---|---|---|---|
| Name:_____ | Age:_____ | Name:_ | Age:_____ |
| Name:_____ | Age:_____ | Name:_ | Age:_____ |
| Name:_____ | Age:_____ | Name:_ | Age:_____ |

Name(Print):_____ Name (signature):_____ Date:_____