Wilson Family Chiropractic

It is our pleasure to welcome you to our office. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____

Name of Parents/ Guardians: _____

Address: _____ City _____ State_____ Zip _____

Cell Phone (mother): _____ Cell Phone (father): _____

Email: _____

Patient Date of Birth: _____ Sex M / F Height _____ Weight _____ # of Siblings _____

How did you hear about our office? _____

Reason for seeking chiropractic care: _____

Other doctors seen for this condition (circle) Yes / No

If yes, doctors names and prior treatments: _____

Other health concerns: _____

Health goals: _____

Has your child ever experienced (check all that apply)?

- o Broken bones
- o Chronic ear aches/infections
- o Neck problems
- o Joint problems
- o Backaches
- o Walking problems
- o Arm problems
- o Leg problems
- o Muscle jerking
- o Tremors
- o Orthopedic problems
- o "Growing pains"
- o Arthritis
- o Neuritis
- o Paralysis
- o Headaches
- o Hyperactivity
- o Behavioral problems
- o Learning disabilities
- o Autism
- o Ruptures/hernias
- o Seasonal allergies
- o Food allergies
- o Frequent colds/flu
- o Diabetes
- o Digestive trouble
- o Asthma
- o Sinus trouble
- o Constipation
- o Diarrhea
- o Colic
- o Anemia
- o Poor appetite
- o Stomach aches
- o Bed wetting
- o Tuberculosis
- o Rheumatic fever
- o Convulsions
- o Blood disorders
- o Heart trouble
- o Hypertension
- o Dizziness
- o Fainting
- o Other: _____

Previous Chiropractor(s): _____ Are you satisfied with the care your child received there? Yes / No

Reason for Care _____

Name of Pediatrician: _____ Are you satisfied with the care your child received there? Yes / No

Reason for Care: _____

Number of antibiotics you 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: _____ During their lifetime: ____

Vaccination History _____

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PRENATAL HISTORY

Type of Birth Attendant: OB/GYN / Midwife / Doula Name(s): _____

Location of Birth: Home / Birthing Center / Hospital

Complications during pregnancy: Yes / No If yes, please list: _____

Ultrasound during pregnancy: Yes / No Number: _____

Medications during pregnancy/ delivery: Yes / No If yes, please list: _____

Cigarette/ Alcohol use during pregnancy: Yes / No

Birth Intervention: Forceps / Vacuum / Caesarian Planned or Emergency? _____

Complications during delivery: Yes / No If yes, please list: _____

Genetic disorders or disabilities: Yes / No If yes, please list: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____

FEEDING HISTORY

Breast Fed: Yes / No How long? _____ Formula Fed: Yes / No How long? _____

Type: _____ Introduced to solids at: _____ months, Cow's milk at _____ months

Food/ juice allergies or intolerances: Yes / No If yes, please list: _____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night: _____ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

_____Respond to sound

_____ Respond to visual stimuli

_____ Hold head up

_____ Sit up

_____ Cross crawl

_____ Stand alone

_____ Walk alone

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? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No

Has your child ever been involved in a car accident? Yes / No

Other traumas not described above: Yes / No Date _____

Prior surgery: Yes / No Type and Date: _____

Onset of menstruation: _____

CHILDHOOD DISEASES

Chicken Pox Y / N Age _____

Mumps Y / N Age _____

Rubella Y / N Age _____

Rubeola Y / N Age _____

Whooping Cough Y / N Age _____

Other: _____

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WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees incurred in this office.

Name: _____ Date: _____/_____/_____

Signature: _____

Witness: _____ Date: _____/_____/_____

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Family Health History

Patient Name: _____ Date: _____/_____/_____

Please review the below listed symptoms and conditions and indicate those are current health problems of a family member by the designated **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

Condition	Father Age_____	Mother Age_____	Spouse Age _____	Brother (s) Age(s) _____	Sister(s) Age(s) _____	Children Age(s) _____
Allergies						
Anxiety/Depression						
Arthritis						
Auto Accidents						
Back Pain						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Epilepsy						
Frequent Colds						
Gassy/Bloating						
Headaches						
Heartburn						
Heart Trouble						
High Blood Pressure						
Migraines						
Neck Pain						
Scoliosis						
Sinus Trouble						
Sleeping Problems						
Other:						

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Emergency Contacts

Patient Name: _____ Date: _____/_____/_____

1st Contact

Name: _____

Relationship: _____

Phone: _____

2nd Contact

Name: _____

Relationship: _____

Phone: _____

Wilson Family Chiropractic

Health Information Privacy Notice

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

During your case as a patient in our office, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it necessary to refer you for further diagnosis, assessment, and treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your attorney (for personal injury or auto accident), or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or via email. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.
- Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
    - If we are providing health care services to you based on the orders of another health care provider
    - If we provide health care services to you in an emergency
    - If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
    - If there are substantial barriers to communicating with you, but in our professional judgment, we believe that you intend for us to provide care
    - If we are ordered by the courts or another appropriate agency
- Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization
- We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preference.
- You have the right to inspect and/or copy your health insurance information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided in writing.
- We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of your privacy practices with respect to your health information.
- We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.
- If you have a complaint, or would like further information regarding our privacy notice, policies, and practices, please direct your inquiry or complaint to:

  Drs. Jacob & Katherine Wilson, Privacy Officers for Wilson Family Chiropractic

- This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patient being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open-adjusting" environment, other arrangements will be made for you.
- Since this office utilizes an "open-adjusting" environment, established patient occasionally request family members or friends be present during their visits. It is the policy of this office to allow for this.
- This office utilizes the use of patient names in some of it's interior/exterior designs of the office. For example, referral boards (acknowledging patients who have referred other patients), welcome boards which display patient names, testimonial books, and website testimonials where patients have written personal health information as well as the benefits of their care in this office. It is our view that these kinds of materials are known as "incidental disclosures". If however, you do not choose for your name to be displayed or disclosed on any of the above-mentioned materials, please inform us in writing. This entire authorization is valid for (7) years. It is the policy of this office to not disclose any information about you without your prior consent. This office will notify you via phone, email, or personal communication prior to utilizing your name for any reason.

This notice is effective a of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name: _____ Date: _____/_____/_____

Signature: _____

If you are a minor, or if you are being represented by another party

Representative Name: _____ Date: _____/_____/_____

Signature: _____

Description of the authority to act on behalf of the patient: _____

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Photo, Video, and/or Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to allow *Wilson Family Chiropractic* and any associated staff members to use and distribute your photograph, video content, and/or written testimonial.

Right to Revoke: You have the right to revoke this release at any time by providing written notice of your revocation and submitting it to the contact person listed below. Please understand that revocation of this release will not affect any action *Wilson Family Chiropractic* took in reliance on this release before receiving your revocation.

I understand that I am providing the video content and/or written testimonial information to *Wilson Family Chiropractic* and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I hereby grant permission to allow *Wilson Family Chiropractic* to use photographs and videos of me, and my written testimonial. I hereby agree and acknowledge that this content will be released to the public via public relation efforts of *Wilson Family Chiropractic.* I further acknowledge and agree that my photo, video, and/or testimonial may be used by the media.

I waive the right of prior approval and hereby release *Wilson Family Chiropractic* from any and all claims for damages of any kind based on the use of my photo, video, or information contained in my testimonial.

By signing below, I agree and acknowledge that I have read and understood the above release and agree to all terms described. I am of legal age and freely sign this release.

Name: _____ Date: _____

Signature: _____