Chiropractic Case History/Patient Information (Age 0-13) Date: _____

Pediatric Patient Information

Childs Name: **First:** _____ **Last:** _____ **Middle Initial:** _____

Childs Birth Date: ____/____/_____ **Gender:** Male / Female

Mother's Name: _____ **Fathers Name:** _____

Address: _____ **Apt #**:_____
City: _____ **State**: _____ **Zip Code**: _____

Mothers Cell Phone :(___) _____-_____ **Fathers Cell Phone** :(___) _____-_____

Email Address: _____

How did you hear about us? _____

Insurance Information: -- *if copy was made of your insurance card, please omit this section.*
Primary Insurance Co.:_____ Secondary **(if applicable):**_____
ID Number: _____ ID Number: _____
Group Number: _____ Group Number: _____

Current Health Condition
Reason for the visit:
_____
_____

Pediatrician/Family MD: _____ _____
Name Location
Pregnancy History/Problems during Pregnancy: _____
_____

Infant Feeding (if currently infant): Breast ____ Formula ____

Number of Hours of Sleep per Night: _____ Quality of Sleep (Circle): Good Fair Poor

Has the child ever suffered from (check all that apply):

__Dizziness	__ Bed Wetting	__ Chronic Earaches	__Diabetes	__Digestive Disorders
__Headaches	__Heart trouble	__ "Growing Pains"	__Fainting	__Hyperactivity
__Hypertension	__Allergies	__Neck problems	__Convulsions	__Asthma
__Constipation	__Diarrhea	__Sinus trouble	__Behavioral problems	__Stomach Aches

Present History/Allergies: _____
_____
Medications (Name/Dosage/For What):_____
_____

UNITED HEALTH
CHIROPRACTIC
3212 14th Ave S Ste 2
Fargo, ND 58103

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Date_____ _____

Print Patient Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____

Signature of Parent/Guardian (circle one)

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations are extremely uncommon as chiropractic is one of the safest forms of healthcare available for musculoskeletal problems. They include, but are not limited to: muscle strain, disc and vertebral injury, strains, and costovertebral strain. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

Date_____ _____

Print Patient Name

_____

Signature of Parent/Guardian (circle one)

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