Pediatric Patient Application

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line)

Section 1: Patient Information Appt. Date: _____/_____/_____

Name: _____ Middle Initial: _____ Age: _____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ___ /____ /_____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Who is responsible for this bill? _____

☐ Father's Social Security #_____-_____-_____ ☐ Mother's Social Security #_____-_____-_____

☐ Other *(please explain)*: _____

Pediatrician/Family MD _____City/State _____

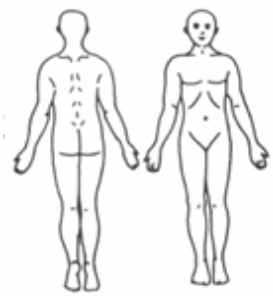
Last Visit: ____/____/____ Reason for visit:_____

Who may we thank for referring you? _____

Section 2: History of Complaint

Health Concerns:	Rate Severity 1 = mild 10 = unbearable	When did it start?	Have you had it before, when?	Did the problem begin with an injury	Is it consistent Or intermittent?
Example: Low back pain	***6***	***1/10/15***	***1/15/13***	***shoveling snow***	***intermittent***
1.					
2.					
3.					

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness
S = **S**harp/**S**tabbing **T** = **T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Whom have you seen in the past for this condition? _____

Any bowel/bladder problems since this health concern began? _____

When is it at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

Continued on back

Section 3: Current Health Problems (Please Circle)

This allows the Doctor to have an overall view of your health status

Headaches	Orthopedic Problems	Digestive Disorders	Behavioral Problems
Dizziness	Neck Problems	Poor Appetite	ADD/ADHD
Fainting	Leg Problems	Stomach Aches	Hernia
Seizures/Convulsions	Arm Problems	Reflux	Muscle Pain
Heart Trouble	Joint Problems	Constipation	Growing Pains
Chronic Earaches	Backaches	Diarrhea	Asthma
Sinus Trouble	Poor Posture	High Blood Pressure	Walking Trouble
Scoliosis	Anemia	Chronic Colds/Flu	Sleeping Problems
Bed Wetting	Colic	Broken Bones	Fall of swing
Fall in baby walker	Fall from bed/couch	Fall from crib	Fall down stairs
Fall off bicycle	Fall from high chair	Fall off slide	Nervousness
Fall from changing table	Fall from monkey bars	Fall off skateboard/skates	

Section 4: Past Health History

Circle any condition you have now or have had: Stroke Cancer Heart disease Spinal surgery Seizures Spinal bone fracture Broken bone Dislocation Cerebral vascular disease Scoliosis Diabetes Knocked unconscious Tumors Rheumatoid arthritis Osteoarthritis Cancer

Explain: _____

List all surgical operations and years: _____

When was your last auto accident? _____

When was your last sports injury? _____

Have you ever had previous chiropractic care (if so when and by whom)? _____

_____

Other trauma: _____

_____

List all medication and supplements: _____

_____

List all allergies: _____

_____

Section 5: Family Health History

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ children

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

_____

I hereby authorize payment to be made directly to Aurora Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Aurora Chiropractic for any and all services I receive at this office.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____	____ - ____ - ____	_____	____ - ____ - ____
Patient or Authorized Person's Signature	**Date Completed**	**Doctor's Signature**	**Date Form Reviewed**

Section 6: Informed Consent

Regarding Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Aurora Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Regarding X-Rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Section 7: Notice of Privacy Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). . In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. I understand that this information can and will be used to:

1. Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.
4. Emergency - in the event of a medical emergency we may notify a family member
5. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICE containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ ____/____/____ *Witness Initials*

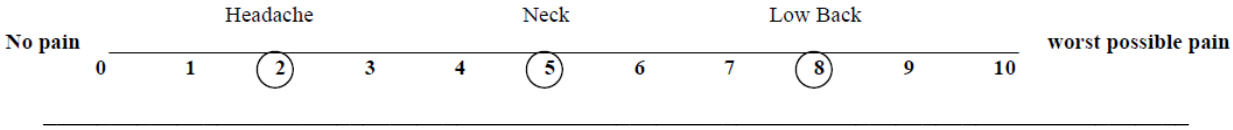
Patient or Authorized Person's Signature Date

Continued on back

Section 8: Quadruple Visual Analog Scale (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

Example:



1. How would you rate your pain **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

2. How would you rate your pain on **AVERAGE**?

0 1 2 3 4 5 6 7 8 9 10

3. How would you rate your pain **AT ITS BEST**?

0 1 2 3 4 5 6 7 8 9 10

4. How would you rate your pain **AT ITS WORST**?

0 1 2 3 4 5 6 7 8 9 10

Office Use Only

Current: _____ ***Goal:*** _____

Section 9: Activities of Daily Living

ACTIVITIES:	EFFECT:			
Carry/Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Use the Computer	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Get Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Perform Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Perform House/Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Wash/Bath/Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Do Dishes/ Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
To Drive	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

_____ **Patient or Authorized Person's Signature**

_____ - _____ - _____ **Date Completed**

_____ **Doctor's Signature**

_____ - _____ - _____ **Date Form Reviewed**