LIFETIME Spines
ADULT AND PEDIATRIC CHIROPRACTIC

Dr. Sorayya Toloue, DC

Pediatric Health History

Patient Name: _____Date:_____

Age:_____ Date of Birth: _____ Cell Phone:_____

Parent and Guardian Names: _____

Address:_____
City:_____State:_____Zipcode:_____

Email Address:_____

Who may we thank for referring you? _____
Date of last Chiropractic visit?_____

Please Check reasons for pursuing chiropractic care for your child:

_____ She/He is continuing care from another chiropractor.
_____ I recently had my spine checked and I see the value in getting my child checked.
_____ I want to improve my child's immune function.
_____ I have no idea why we are here. Please explain to me what chiropractic care can do for children.
_____ She/He has a specific condition that concerns me. Please explain condition or symptom:
_____

Please circle any of the following which you child currently has or has had previously:

Headaches	Postural Imbalance	Asthma	Allergies	ADD/ADHD
Scoliosis	Sinus Problems	Seizures	Growing/Back Pains	Bedwetting
Car Accident	Ear Infections	Colic	Digestive Problems	Food Intolerance
Autism	Frequent Colds	Other:_____		

Please list any known allergies:_____
Please list any prescription or over the counter medications your child is currently taking/has taken:
_____

Number of doses of Antibiotics your child has taken: _____
During the past 6 months: _____Total in their lifetime:_____
List reasons:_____

Prenatal History:

Location of Birth: Hospital Home Birthing Center

Adopted?	Y	N	
Complications during pregnancy?	Y	N	If Y, List:_____
Ultrasounds during pregnancy?	Y	N	If Y, how many?_____
Medications/drugs/caffeine during pregnancy?	Y	N	If Y, List:_____
Alcohol/Tobacco during pregnancy?	Y	N	If Y, List:_____

Birth Intervention:

Mother induced?	Y	N	
Mother medicated? (Pitocin, etc)	Y	N	
Forceps	Y	N	
Vacuum Extracted	Y	N	
Baby given medication	Y	N	
Complications during delivery?	Y	N	If Y, List:_____
Genetic disorders or disabilities?	Y	N	If Y, List:_____
Breast Fed?	Y	N	How long:_____
Formula Fed?	Y	N	How Long:_____

◆According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie. a bed, changing table, down stairs etc.) was this the case with your child? If Yes, please list:_____

◆Is/ Has your child been involved in any high impact or contact sports? (Soccer, Football, Gymnastics, Hockey, Baseball, Cheerleading, Martial arts etc) If Yes, please list:_____

◆Has your child been seen on an Emergency Basis? If Yes, please list:_____

It is important that we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

_____

Parent/Guardian Signature Date

Informed Consent

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I realize that an X-ray examination may be required, and may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

I may request a copy of the HIPPA and Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

I grant permission to be called or texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I have received information about my condition and proposed chiropractic treatment program as well as alternative course of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment. I understand that, as in all health care, in the practice of chiropractic, while very rare, there are some risks to treatment. Risks include, but not limited to, muscle strain, ache, sprain, fracture, dislocation and stroke. I wish to rely on the doctor to exercise judgment during the course of the treatments based upon the facts then known, that is in my best interest.

My doctor has responded to all of my requests for information about the proposed treatment. I have read the above consent and by signing below I have consented to treatment.

_____

Patient's Name (Printed) Patient's Signature Date

_____

Parent/Guardian Name (Printed) Parent/Guardian Signature Date

_____

Witness' Name (Printed) Witness' Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

_____

Patient or Legally Authorized Individual Signature

_____

Date Time

_____

Print Patient's Full Name

Witness Signature _____