ZAO CHIROPRACTIC PEDIATRIC HEALTH PROFILE

Name_____ Date of Birth_____/_____/_____ Age_____ Male / Female

Address_____City_____State_____Zip_____

Parent/Guardian Name(s)_____Relationship(s)_____

Phone Number_____Siblings_____

Height_____ Weight_____

Office Only _____

Pediatrician/Family MD_____ City/State _____

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

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW:

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor? _____ Medical Doctor? _____Other_____

Who and When?_____

PLEASE MARK "**P**" FOR IN THE **PAST** OR MARK "**C**" FOR **CURRENTLY** HAVE:

___HEADACHE/MIGRAINE	___HEARING LOSS	___LOSS OF ENERGY	___LOSS OF BALANCE
___EAR INFECTIONS	___SLEEP PROBLEMS	___POOR POSTURE	___BACK/NECK PAIN
___SCOLIOSIS	___EATING PROBLEMS	___TEMPER TANTRUMS	___BLADDER PROBLEMS
___ADD/ADHD	___GASTRIC REFLUX	___ANXIETY	___DIGESTIVE PROBLEMS
___BED WETTING	___ANXIETY	___FREQUENT COLDS	___HEART PROBLEMS
___DEVELOPMENTAL DELAY	___DEPRESSION	___DIABETES	___KIDNEY PROBLEMS
___GROWING PAINS	___NERVOUSNESS	___LEG/ARM/JOINT PAIN	___THYROID PROBLEMS
___SCOLIOSIS	___CONSTIPATION	___JAW PAIN	___SPORTS INJURY
___SEIZURES	___DIARRHEA	___ULCERS	ANY KNOWN DIAGNOSES__
___SINUS ISSUES	___NAUSEA	___RINGING IN THE EARS	_____
___ASTHMA	___ALLERGIES	___DOUBLE/BLURRY VISION	_____
___COLIC	___SKIN PROBLEMS	___DIZZINESS	_____

Pregnancy Information

Briefly describe your pregnancy_____

Any pregnancy complications? _____

Any drugs/medication during pregnancy? _____

Other information_____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section None

Induced Labor? YES / NO

If yes, please explain_____

Medications received during delivery_____

Other information_____ _____

Post Partum Information

Birth Weight_____Birth Length_____APGAR SCORE_____

Breast Fed? YES / NO How long? _____ Formula Fed? YES / NO How Long? _____

Age Introduced to Solid Foods_____

Food Allergies or Intolerances_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____Total lifetime_____

Current prescription medication/dosage? _____

Over the counter medication (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years_____

Trauma Information

Has your child ever been knocked unconscious? YES / NO Fractured A Bone? YES / NO

If yes to either, please describe_____

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)

Did your child have a fall similar to what was described above? YES / NO

Explain_____

Quadruple Visual Analogue Scale

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

EX: No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Headache Hip Pain

1. How would you rate the symptom/pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is the typical or AVERAGE of the symptom/pain? (How bad is the symptom/pain throughout most of a day?)

0 1 2 3 4 5 6 7 8 9 10

3. What is the symptom/pain level at its BEST? (How close to 0 does the symptom/pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the symptoms/pain at its best? _____%

4. What is the symptom/pain level at its WORST? (How close to 10 does the symptom/pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the pain at its worst?_____%

Activities of Life

Please identify how your child's ability to carry out activities that are routinely part of life are affected by current condition

ACTIVITIES:		EFFECT:		
Holding Head Up	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Tummy Time	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Nursing	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Sitting Up	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Crawling	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Standing Alone	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Walking Alone	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Other: _____	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Other: _____	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Written Consent For A Child

CHILD'S NAME_____

I AUTHORIZE DR. DYLAN ROY AND ANY ZAO CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY ZAO CHIROPRACTIC.

_____ _____ _____/_____/_____
Parent/Guardian Name Parent/Guardian Signature Date

_____
Relationship to Minor / Child

Notice of Privacy Practices 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). I understand that this information can and will be used to:

1. Conduct, plan and direct my 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.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES 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.

_____ _____/_____/_____
Parent/Guardian Signature Date

Medical Information Release Form

Name_____Date of Birth_____/_____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

_____ _____/_____/_____

Parent/Guardian Signature Date

Authorization for Use or Disclosure of Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Zao Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images and/or testimonial will be used for: *In-office material*, *Merchandise*, *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Treatment Conditions:
I understand that the practice cannot and will not condition treatment based on whether or not I sign this authorization.

Parent/ Guardian_____

Date_____

Signature_____

Office Only_____

Date _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH UPPER CERVICAL ADJUSTMENT IS EXTREMELY REMOTE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD(UNDER THE AGE OF 18), PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**