PEDIATRIC HISTORY FORM **SALT LAKE CHIROPRACTIC**

Name:_____Email:_____

Birthday: _____ Referred by:_____

Phone: _____(home) (cell) Work Phone: _____

Address: _____City: _____

State: _____ Zip: _____ Siblings: (y) (n)

Parent Names: _____ Parent Birthdays:_____

Emergency Contact: _____Phone: _____

Pediatrician:_____Phone:_____

Please circle all that apply.

Antibiotics	Difficulty Sleeping	Colic	Digestive Troubles
Ear Infection	Asthma/Allergies	Feeding difficulties	Bed Wetting

Delivery history: (natural) (home) (hospital) (c-section) (vacuum) (forceps) (emergency)

Name of OBGYN/Midwife: _____ # of Ultrasounds: _____

Complications during pregnancy: (y) (n) _____

Complications during delivery: (y) (n) _____

Medications during pregnancy/delivery: (y) (n) _____

Cigarette/Alcohol during pregnancy: (y) (n)

Breastfed? (y) (n) How long? ____ Formula fed? (y) (n) _____Solids (y) (n) Age:____

Food or juice allergies? _____

Reason for Care: Wellness/family care (y) (n) Health Concern:_____

How did it start and when: _____

What makes it better?_____What makes it worse?_____

How often? (daily) (weekly) (monthly) Constant? (y) (n) Severity? 1 (low)- 10 (high): _____

List any accidents, injuries, falls, or surgeries: _____

List any current drugs/medications: _____

List any current vitamins/herbs/supplements:_____

PHILOSOPHICAL AGREEMENT

Health is the state of optimal physical, mental and social well-being, not merely the absence of disease. We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interference to the expression of the body's innate wisdom and to support your body to hold and integrate your adjustments. If you desire advice, diagnosis or treatment of specific diseases, we encourage you to seek the counsel of a medical disease care specialist.

PRIVACY POLICY

Salt Lake Chiropractic is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from Salt Lake Chiropractic. Salt Lake Chiropractic may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. If you are attending our open adjusting please consider that there may be other clients in the room with you and any information exchanged between yourself and the doctor may be overheard. If you need a private consultation please request one. Salt Lake Chiropractic may use and/or disclose your PHI, without a written Consent from you, in the certain instances in which you may request Salt Lake Chiropractic may contact you with appointment reminders or to provide information about treatment alternatives or other health-related services and options that may be of interest to you. Salt Lake Chiropractic may disclose your PHI to a family member, other relative,close personal friend, or any other person that you have identified, as long as your PHI is directly relevant to such person‘s involvement with your care or the payment for your care. You have the right to request your Privacy Rights, please ask the front desk for a copy.

FINANCIAL AGREEMENT

We are an out-of-network health provider. Should your insurance company offer out-of-network benefits under your plan we may be able to bill your insurance for you as a courtesy. We will give you a financial consultation of what Salt Lake Chiropractic services your benefits cover on your second visit if the Insurance Verification form has been completed on your your first visit. You are welcome to request a receipt for your visits and submit it to your insurance company for reimbursement based on what your policy covers. Follow up adjustments are $40. You may choose to prepay for a series of adjustments and receive a discount. If plan is prematurely canceled, you will be refunded and retroactively charged $40/ visit for services rendered. Returned checks are subject to a $25 fee. Fees are payable when service is rendered unless other arrangements have been made in advance.

The information provided above is true to the best of my knowledge.

I have read the above statements and understand Salt Lake Chiropractic’s objectives pertaining to my care in this office.

Signature _____Date _____

Please sign for consent to evaluate and adjust a minor/child.

Signature _____Date _____