Tinker Family Chiropractic Pediatric History Form

Today's Date: _____ HRN: _____

Child's Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Current Weight: _____ Current Height: _____

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

Mother's Name: _____ Cell Phone: _____ DOB: _____-_____-_____

Father's Name: _____ Cell Phone: _____ DOB: _____-_____-_____

E-mail Address: _____ Do you have Insurance: ☐ Yes ☐ No

Pediatrician/Family MD: _____ City/State: _____ Last Visit ___ /___ /___

Number of siblings and Ages: _____

Name of Previous Chiropractor: _____ *(☐ I've never been to a chiropractor)*

Who is responsible for this bill? _____

Who can we thank for referring you to our office? _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ____ Wellness Check-up ____ Injury or Accident ____ Other - Please explain: _____

If your child is experiencing pain/discomfort please identify where _____ and for how long _____

When did the problem first begin? Date ____ /____ /_____ _____Unknown _____Gradual _____Sudden

Was this problem a result of any type of accident? *YES* *NO* *Please explain:* _____

Have they ever had this problem before? *YES* *NO* If yes, when? _____

Any bowel or bladder problems since this problem began? *YES* *NO* (Describe)_____

Have you seen any other doctors for this problem? *YES* *NO* If yes, who? _____

How long ago? _____Days _____ Weeks _____ Months _____Years

What were the results of past treatment? _____

How is this problem NOW: ☐ Rapidly Improving ☐ Slowly Improving ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem: _____

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Neck Pain	___ Back Aches	___ Orthopedic Problems	___ Muscle Pain
___ Dizziness	___ Frequent Colds/Flu	___ Loss of Balance	___ Fainting	___ Seizures
___ Poor Appetite	___ Convulsions/Epilepsy	___ Diarrhea	___ Constipation	___ Digestive Disorders/Stomach Ache
___ Joint Problems	___ Arm Problems	___ Leg Problems	___ Bed Wetting	___ Behavioral Problems
___ Asthma	___ ADD/ADHD	___ Vision Issues	___ Ear Ache/Infections	___ Frequent Sickness (cold/flu)
___ Reflux/Colic	___ Anemia	___ Sinus Trouble	___ Depression/Anxiety	___ Broken Bones/Fracture
___ Scoliosis	___ Poor Posture	___ Diabetes	___ Sleeping Problems	___ Learning Disability
___ Hypertension	___ Skin Problems/Eczema	___ Heart condition	___ Allergies (To: _____)	

___Cancer (Type: _____) ___ Other conditions/diagnoses not listed: _____

_____

Patient's Name: _____ **Date:** _____

On a scale of **1** to **10**, with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling*** *the number*.

If you have more than one symptom, please label each one accordingly.

For example: 0 - (1) - 2 - 3 – (4) – 5 – 6 – (7) – 8 – 9 – 10

Headaches Neck Low Back

What is your pain **RIGHT NOW**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your **TYPICAL or AVERAGE** pain? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your pain level **AT ITS BEST**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your pain level **AT ITS WORST**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Does anything you do **aggravate** your child's condition(s): ☐ **No** ☐ **Yes** If **yes,** what? _____

Does anything **relieve** your child's condition? ☐ **No** ☐ **Yes** If **yes**, what? _____

DAILY ACTIVITIES: Please identify how your child's condition is affecting their ability to carry out daily activities of life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.

The risks associated with exposure to x-rays and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

☐ 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.

_____ _____ _____ _____

Parent or Legal Guardian's Signature **Date Completed** **Doctor's Signature** **Date Reviewed**

Patient's Name: _____ **Date: _____**

Since problems that Chiropractors look for and detect can be related to many types of stressors, the following information is very important to us.

Has your child had COVID-19? *Yes or No* If yes, when? _____

Has your child received one or more COVID-19 vaccines? *Yes or No* If so, how many & which one?_____

HISTORY OF BIRTH

What was the child's gestational age at birth?_____weeks.

Birth weight_____lbs_____oz Birth length_____inches.

Was your child born *☐ at home ☐ in a birthing center ☐ in a hospital*

Was the birth considered *☐ medical ☐ midwife*

What was the duration of the labor and birth?_____hours.

Was the child born *☐ cephalic (head first) ☐ breech (feet first)*

Were there any complications? *YES NO* If yes, please explain_____

Please circle any assistance which was used at birth: *Forceps Vacuum Extraction C-section Episiotomy*

Was labor *☐ spontaneous ☐ induced*

Were medications or epidurals given to the mother during birth? *YES NO*

If YES, what was given? _____

APGAR score: at Birth_____/10 After 5 minutes_____/10

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (I.e. Falls, accidents, etc.) *YES NO*

If YES, please explain_____

Any evidence of birth trauma to the infant? (please check)

___bruising ___odd shaped head ___stuck in birth canal

___fast or excessively long birth ___respiratory depression ___cord around neck

Any falls from (circle): *couch bed/crib changing table high chair bicycle slide downstairs swing*

*Others not listed, please explain*_____

Any traumas resulting in bruises, cuts, stitches, or fractures? *YES NO*

*If YES, please explain*_____

Any hospitalizations or surgeries? *YES NO*

*If YES, please explain*_____

Any sports played? _____

Has your child ever sustained an injury playing sports? *YES NO*

If YES, please explain_____

Has your child ever sustained an injury in an auto accident? *YES NO*

If YES, please explain_____

Is a school backpack used? *YES NO Is it HEAVY or LIGHT (circle)*

CHEMICAL STRESSORS

Was this child breast-fed? *YES* *NO* If YES, how long?_____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____Began solid foods at what age? _____

Food/Juice intolerance? *YES* *NO* Type?_____

During pregnancy, did the mother smoke? *YES* *NO* How much?_____

During pregnancy, did the mother drink? *YES* *NO* How much?_____

Any illnesses during pregnancy? *YES* *NO*

Any supplements taken during pregnancy? *YES* *NO* Which ones? _____

Any drugs taken during pregnancy? *YES* *NO* Which ones? _____

Any ultrasounds? *YES* *NO* How many?_____

Any invasive procedures during pregnancy (i.e. amniocentesis etc.)? *YES* *NO*

If YES, please explain_____

Any pets at home? *YES* *NO*

Any smokers at home? *YES* *NO*

Vaccinations and age given_____

Any negative reactions (including "mild" reactions)? *YES* *NO*

If YES, please explain_____

Any antibiotics given? *YES* *NO*

If YES, please give name_____

List Prescription & Non-Prescription drugs or supplements your child takes:_____

_____

_____

PSYCHOSOCIAL STRESSORS

Any difficulties with latching? *YES* *NO*

Any problems with bonding? *YES* *NO*

Any behavioral problems? *YES* *NO*

Any night terrors, sleep walking, difficulty sleeping? *YES* *NO*

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel your child's social and emotional development is normal for their age? *YES* *NO*

Thank you for completing this form. If there are any other questions or concerns that you have, write them in the space below.

_____

_____

We are here to help you and your family reach your God-given potential, in Health and in Life!!

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 Tinker Family 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 child's condition at any time throughout the entire clinical course of my child's care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

MENSTRUATING 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 child's case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, _____authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

_____ _____
Signature of Parent or Legal Guardian Date

Tinker Family Chiropractic's Office Policies

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

Tinker Family Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Tinker Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

OUR OFFICE POLICIES

Welcome to Tinker Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Tinker Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Diversified Full Spine, Thompson, Activator, and Arthrostim. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Tinker Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. 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. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. 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 up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Tinker at (615) 948-3790 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201