PEDIATRIC HEALTH RECORD

ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE:

GENDER: | WEIGHT :

EMPLOYER:

EMPLOYER NUMBER: | OCCUPATION:

ABOUT THE PARENT

PARENT NAME:

ADDRESS:

☐ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

WORK PHONE: | OCCUPATION:

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD?

☐ YES ☐ NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:

☐ DPT ☐ MMR ☐ CHICKEN POX ☐ HEPATITIS ☐ OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAS CHILD BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

☐ YES ☐ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITIS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

WHEN DID THIS CONCERN BEGIN?

HAS THIS CONCERN:

☐ GOTTEN WORSE ☐ STAYED CONSTANT ☐ CAME AND GONE

DOES THIS CONCERN INTERFERE WITH:

☐ SCHOOL ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONCERN OCCURRED BEFORE? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN ? ☐ YES ☐ NO

DOCTORS NAME:

TYPE OF TREATMENT:

RESULTS:

☐ GOOD ☐ BAD ☐ INDIFFERENT

SURGERIES: _____

If applicable:

WHEN is the date of FIRST DAY MENSTRAL CYCYLE? _____

When is the first day of your last mentral cycle? _____

Infinity Wellness Center
4716 4th Street Suite 102
(806)224-0063
Lubbock, TX 79416

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:

☐ DRUGS/MEDICATIONS ☐ TOBACCO/ALCOHOL

IF YES, PLEASE EXPLAIN:

DESRIBE YOUR DELIVERY:

☐ VAGINAL HANDS-OFF DELIVERY
☐ LABOR WAS CHEMICALLY INDUCED
☐ C-SECTION DELIVERY
☐ DOCTOR PULLED OR TWISTED BABT
☐ LABOR WAS DOCTOR ASSISTED
☐ FORCEPS/VACUUM EXTRACTION
☐ PREMATURE DELIVERY

PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT?

☐ YES ☐ NO

PLEASE EXPLAIN:

DID YOU NURSE THE BABY? ☐ YES ☐ NO

DID YOU EXPERIENCE FEEDING PROBLEMS? ☐ YES ☐ NO

DID YOUR BABY HAVE COLIC? ☐ YES ☐ NO

VACCINATIONS? ☐ YES ☐ NO

REASON FOR THIS VISIT

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care pan and the possibility of being*

☐ ALLERGIES	☐ CONSTIPATION	☐ IRRITABILITY
☐ ASTHMA	☐ DIGESTIVE PROBLEMS	☐ SKIN PROBLEMS
☐ ATTENTION PROBLEMS	☐ EAR PROBLEMS	☐ SLEEPING DISORDERS
☐ BED WETTING	☐ FREQUENT COLDS	☐ TUBES IN THE EARS
☐ BREATHING PROBLEMS	☐ HEADACHES	☐ VISION PROBLEMS
☐ COLIC	☐ HYPERACTIVITY	☐ OTHER:

CHIROPRACTIC EXPERIENCE

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SERVERE FALL? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ☐ YES ☐ NO

PLEASE EXPLAIN:

IS YOUR CHILDACCIDENT PRONE? ☐ YES ☐ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ☐ YES ☐ NO

PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ☐ YES ☐ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICILTY INTERACTING WITH OTHERS?

☐ YES ☐ NO PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

☐ YES ☐ NO PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIORS WOULD YOU LIKE ACCOMPLISHED?

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

☐ YES ☐ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

☐ YES ☐ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

☐ YES ☐ NO

IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?

☐ YES ☐ NO

AUTHORIZATION FOR CARE OF A MINOR

Dr. Johnson has my permission to treat my minor child _____ in my absence.

Persons who I consent to bringing them are: _____ _____

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

***Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

INITIAL IF READ ABOVE: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking chiropractic, A.M.I.T, pulse, Class IV laser, dry needling, cupping, decompression, and/or acupuncture, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

INITIAL IF READ ABOVE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

1. You may request restrictions on your disclosures.
2. You may inspect and receive copies of your records within 30 days with a request.
3. You may request to view changes to your records.
4. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

5. *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
6. *Obtain payment from third party payers.*
7. ***Conduct normal healthcare operations such as quality assessments and physician's certifications.***
8. *You may request super bill, documentary of visits by email.*

I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/ or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT (if minor):
SIGNATURE:	DATE: