EPOCH CHIROPRACTIC
n. [ep-uh k] 1. a point in time beginning a new or distinctive period.
5231 W. Woodmill Dr. Wilmington, DE 19808 | p: 302.635.7421 | f: 302.635.7422 | www.epochchiro.com

PEDIATRIC HISTORY FORM

WELCOME to Epoch Chiropractic! It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____Today's Date: _____

Address: _____

City:_____State: _____ Zip: _____

Home Phone:_____ Parent Cell Phone: _____

Parent Email:_____

Birth Date: _____/_____/ _____ Age: _____ Sex: _____

How Did You Hear About Our Office?: _____

Names of Parents / Guardians:

_____

Reason for Today's Initial Visit:_____

_____

Other Doctors Seen for this Condition:_____ N_____Y
Doctors' Names and Prior Treatments:_____
Other Health Problems: _____

Circle any of the Following Conditions Your Child has had during the Past 6 Months:

Ear Infections Scoliosis Seizures Chronic Colds Headaches ADHD/Hyperactivity

Asthma/Allergies Digestive Problems Recurring Fevers

Growing / Back Pains Colic Bed Wetting Car Accidents Temper Tantrums Other

_____

Family History of Health Problems: _____

_____

Previous Chiropractor: _____

Date of Last Visit: ___ / ___ / ___ Reason:_____

Name of Pediatrician: _____

Date of Last Visit: ___/ ___/ ___ Reason:_____

Are You Satisfied with the Care Your Child has Received There ?____N _____ Y

*Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months:_____ , Total During His / Her Lifetime: _____

*Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months:_____ , Total During His / Her Lifetime: _____

List:_____

Vaccination History: circle one

Regular Vaccine Schedule Delayed Vaccine Schedule Non-Vaccinated

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____N _____Y

List: _____

Ultrasounds During Pregnancy ? _____N _____Y Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y

List: _____

Cigarette / Alcohol Use During Pregnancy: _____N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Interventions: Forceps Vacuum Extraction Caesarian Section

Complications During Delivery ? _____ N_____ Y

List: _____

Genetic Disorders or Disabilities: _____ N_____Y

List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: ___N ___Y How Long: _____ Formula Fed: ___N ___Y How Long: _____

Introduced to Solids at: _____ Months Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: ____N ____Y

List: _____

Developmental History:

Please indicate if there was a **DELAY** in development or concern for proper progression during these important milestones in your child's life:

____ Respond to Sound	____ Crawling	____ Social Play
____ Respond to Visual Stimuli	____ Standing	____ Other
____Hold Head Up	____ Walking	Please list:_____
____ Sit Up	____ Speech	_____

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, etc.). Was this the case with your child? ____ N ____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N_____Y

List: _____

Has Your Child Ever Been Involved in a Car Accident? _____ N _____Y

List: _____

Other Traumas Not Described Above? _____ N _____ Y

List: _____

Prior Surgery: _____N _____ Y if yes, please list:_____

If female, has menarche begun?: _____N _____ Y If yes, what age: _____

Childhood Diseases/Illnesses:

Chicken Pox N / Y, Age_____ Mumps N / Y, Age _____

Rubella N / Y, Age_____ Whooping Cough N / Y, Age _____

Measles N / Y, Age_____

Other N / Y if yes, list with ages: _____

_____

WE ARE HERE TO SERVE YOU, AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP US PROVIDE YOUR FAMILY THE BEST CARE WE CAN!

Our office policy requires payment in full for all services rendered at the time of visit, unless otherwise discussed with the Doctor or Office Manager at Epoch Chiropractic. I understand the above information, and guarantee this form was completed correctly and to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

I know that I may ask to see a copy of the "Notice of Privacy Practices for Protected Health Information". This office uses an open-door adjusting environment, which may involve patients being seen in adjusting areas at the same time, and some routine details of care my discussed within earshot of other patients. I understand this is not the environment for histories, exams, or follow-up reports. Please inform the front desk should you prefer not to be adjusted in an open-door policy.

Patient Name: _____

Parent/Guardian's Signature:_____ Date: _____

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Informed Consent for Chiropractic Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
Doctor signature		Date

Minors:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Females:
Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle:_____

Signature	Date

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ASSIGNMENT, LIEN, AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Epoch Chiropractic, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient: _____ Date:_____

Witness: _____ Date: _____

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Notice of Privacy Practices

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

Contact Person

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer
Epoch Chiropractic – Eternal Health, LLC
5231 W. Woodmill Dr.
Wilmington, DE 19808
302.635.7421

I, Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

Effective Date: This notice is effective October, 1 2011 and applies to all protected health information contained in your medical records maintained by us.