Minor's Health History Form
Billerica Chiropractic Office, PC
25 Bridge St. Billerica Ma. 01821
978-667-1932

Pt# _____

Full Name: _____ Nickname:_____ Date:_____

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

Mother's Name: _____ Cell Phone #:_____

Father's Name: _____ Cell Phone #: _____

Home Phone #: _____ Birth date: _____ Age: _____ □ Male □ Female

Reason for consulting our office: _____

_____

Whom may we thank for referring you? _____

Health Profile

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, & second, to offer you & your child the opportunity of improved health potential & wellness services.

Addressing The Issues That Brought You To The Office

If your child has no symptoms or complaints, and is here for wellness services, please check: ☐.
If there is a specific issue, briefly describe the chief area of complaint, including the effect it has on the child: _____

_____

If he/she is experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant

Since the problem started, is it: ☐ About the same ☐ Getting better ☐ Getting Worse?

What makes it worse? _____

It interferes with: ☐ School ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Other: _____

Other doctors seen for this problem:

Chiropractor: _____ Ph # _____

Pediatrician: _____ Ph # _____

Other: _____ Ph # _____

May we have permission to contact these doctors? YES / NO

List any medications the child is currently taking:

_____

_____

List any allergies the child has: (seasonal, medications etc.)

_____

_____

Daily we experience **physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life.** Answering these questions will give us information that will allow us to better assess the challenges to you child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? ☐ Yes ☐ No
If yes, explain: _____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who? _____

Was the baby ever in Breech position? ☐ Yes ☐ No
How many ultrasounds were preformed? _____

Birth & Delivery

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Was the delivery: ☐ Vaginal ☐ C-section Were any devices used? ☐ Forceps ☐ Vacuum
How long was the labor? _____ How long was the delivery? _____

Was oxytocin / pitocin used? ☐ Yes ☐ No Was an epidural administered? ☐ Yes ☐ No

Infancy:

Was the infant vaccinated? ☐ Yes ☐ No

Was there any prolonged use of medicines or an inhaler? ☐ Yes ☐ No If yes which? _____

Did the infant suffer any traumas such as serious falls or car accidents? ☐ Yes ☐ No

Has the infant been under regular chiropractic care? ☐ Yes ☐ No

Childhood years:

Did the child have any childhood illnesses? ☐ Yes ☐ No Explain: _____
_____

Does the child play youth sports? ☐ Yes ☐ No Which sport(s)? _____
_____

Has the child had any surgery? ☐ Yes ☐ No Explain: _____
_____

Has the child fallen from a height over 3 ft? ☐ Yes ☐ No Explain: _____
_____

Continued:

Was the child involved in any car accidents? ☐ Yes ☐ No Explain: _____
_____

Has there been any prolonged use of meds? ☐ Yes ☐ No Explain: _____
_____

Has the child suffered emotional traumas? ☐ Yes ☐ No Explain: _____
_____

Please give us any other health information you feel would be helpful: _____
_____
_____

Does the child carry a book bag to school? Yes / No Carries over 1 shoulder___ On both shoulders___

Quality of sleep: Good___ Fair____ Poor____ # of hours of sleep per night: _____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature: _____ Date: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Billerica Chiropractic office will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name _____ Signature _____ Date _____

Guardian's Name _____ Signature _____ Date _____

BILLERICA CHIROPRACTIC OFFICE, P.C.
PRIVACY POLICY

THIS NOTICE DESCRIBES HOW CHIRORPACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Billerica Chiropractic Office we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO a PPO or your employer, if they are or may be responsible for the payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your recent care or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

If we provide health care services to you in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to review this information at an address other than your home, or, if you would like the information in a specific form please advise us in writing as to your preferences.
You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Alesia, our office manager.

If you would like further information about our privacy policies and practices please contact Dr. Honi Kawut or Dr. Sanford Chapnick.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue, and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Printed Name	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____	_____
Guardian Name	Guardian Signature	Date

BILLERICA CHIROPRACTIC OFFICE, P.C.
PATIENT AUTHORIZATION RELEASES

Authorization For Appointment Reminders and Scheduling Related Matters: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____
Printed Name Signature Date

Authorization For Thank You Cards, Birthday Cards, Welcome Letters and Newsletters: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to thank you for referring someone to our office; to send you birthday wishes; or to send you our newsletter.

The use of this information is intended to further enhance the quality of your experience with our office. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic Office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____
Printed Name Signature Date

Authorization For Contact Regarding Chiropractic Care, Related Health Services and/or Related Health Products: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic Office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____
Printed Name Signature Date

Any or all of the above authorizations may be revoked by you, at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.