Thrive Wellness Center – A Wellness Way Affiliate
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PEDIATRIC HISTORY FORM

Whom may we thank for referring you to the office? _____

PATIENT DEMOGRAPHICS

Child's Name: _____ **Today's Date** _____/ _____/ _____ **HR#:** _____

Date of Birth: _____/ _____/ _____ **Birth Height:** _____ **Birth Weight:** _____ **Current Height:** _____

Current Weight: _____ **Age:** _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone (Home):** _____

Mother's Name: _____ **Mother's Cell #:** _____ **DOB:** _____/ _____/ _____

Father's Name: _____ **Father's Cell #:** _____ **DOB:** _____/ _____/ _____

Pediatrician / Family MD: _____ **City / State:** _____

Last Visit: _____/ _____/ _____ **Reason for visit:** _____

Who is responsible for this bill? _____

☐ **Father's Social Security #:** _____ - _____ - _____ ☐ **Mother's Social Security #:** _____ - _____ - _____

☐ **Other (please explain):** _____

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):** _____

_____

1. **When did the problem first begin?** **Date:** _____/ _____/ _____ ☐ **Unknown** ☐ **Gradual** ☐ **Sudden**
2. **Ever had this problem before?** ☐ **No** ☐ **Yes** **If Yes, explain when:** _____
3. **Any bowel or bladder problems since this problem began?** ☐ **No** ☐ **Yes** **If Yes, describe:** _____

_____

4. **Have you seen any other doctors for this problem?** ☐ **No** ☐ **Yes** **If so, who?** _____

   How long ago? _____ **Days** _____ **Weeks** _____ **Months** _____ **Years**
5. **What were the results of past treatment(s)?** _____
6. **How is this problem now:** ☐ **Rapidly Improving** ☐ **Improving Slowly** ☐ **About the Same** ☐ **Gradually Worsening**

   ☐ **On & Off**

7. Please list any medication(s) taken: _____

8. Has your child ever sustained an injury playing organized sports? ☐ **No** ☐ **Yes**

If yes, please explain: _____

_____

9. Has your child ever sustained an injury in an auto accident? ☐ **No** ☐ **Yes**

If yes, please explain: _____

_____

HAS YOUR CHILD EVER SUFFERED FROM: Please **checkmark** (✓) for **YES** or leave **blank** for **NO**

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD / ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures / Hernias
☐ Muscle Pain	☐ Leg Problems	☐ Reflux	☐ Seizures / Convulsions
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds / Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Sleeping Problems
☐ Fall in baby walker	☐ Fall from crib	☐ Fall from bed or couch	☐ Fall from Changing Table
☐ Fall of bicycle	☐ Fall off slide	☐ Fall from high chair	☐ Fall off Skateboard / Skates
☐ Fall of swing	☐ Fall down stairs	☐ Fall off monkey bars	☐ Other: _____

I understand that I am directly and fully responsible to Thrive Wellness Center for all fees associated with the chiropractic care my child receives:

The risks associated with exposure to ionization 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 right to select and authorize health care service on behalf of.

☐ 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 Thrive Wellness Center.

_____ _____

Parent or Legal Guardian's Signature **Date**

_____ _____

Doctor's Signature **Date**

JDD, DC 5/2011

THRIVE WELLNESS CENTER'S 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 your. In addition, you will find we have placed several copied in report folders labeled '**HIPPA**' on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. 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 & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming 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 mailing 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 via email, 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 Thrive Wellness Center at (507) 258-4100. If we are 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

Patient's initials: _____

Thrive Wellness Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

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 any 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 are kept in the reception area. At this time, I do not have any questions regarding my right or any of the information I have received.

_____	_____	_____
Patient's Name	**DOB**	**HR#**

_____	_____
Patient's Signature	**Date**

_____	_____
Witness	**Date**

THRIVE WELLNESS CENTER'S 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 risks are most often 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 Thrive Wellness Center, 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 means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

☐ 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 considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

THRIVE WELLNESS CENTER'S OFFICE POLICIES

Welcome to Thrive Wellness Center!

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 reach 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 "Thrive Wellness Center's Office Policies," if you have any questions or 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. 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 patient as 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 changed 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 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 a time for you to speak to the doctor in a private consultation room. These consultation 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 **Thrive Wellness Center** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the bodies innate wisdom. The doctors use specific corrective techniques to accomplish this goal, including but not limited to
CLEAR INSTITUTE. 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 no 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 corrections 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 your along with care plan recommendations so that 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 you 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 doctors' recommendations for care, will be discussed at this time, we require each new patient 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.

Thrive Wellness Center's OFFICE POLICIES continued...

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 understand 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's Signature	**Date**

_____	_____
Witness	**Date**