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Pediatric/Youth Health Profile (Ages 13 and under)

*Please do your best to fill out *everything* on this intake form. It is important that we understand past and current stressors that may have affected or could affect your child's health. It is important for us to know the following information, even if it may not seem relevant to the reason for which you are coming in for care. Please know that we value your time and aim to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic and Wellness Center!

Check type of care desired: __Temporary Relief / __Stabilization / __Family Health/ Prevention/ __Doctor's Advice

Child's Name _____ DOB _____ Age _____ Sex _____

Siblings' Names and Ages: _____

Parent's Name _____ Work Phone _____ Cell _____

Parent's Name _____ Work Phone _____ Cell _____

Address _____ City_____ State_____ Zip Code _____

Home Phone _____ Email _____

Who referred you to our office? _____

Is this related to an auto accident injury involving a third party? Yes No (If yes, please speak with the front desk.)

Current Concerns

What is the reason for this appointment? _____

When did this situation or concern first begin? _____

Have you done anything for or gotten any advice or treatment for this issue outside of this office? Yes No
Explain:_____

What activities **aggravate** their condition/pain? _____

What activities **alleviate** their condition/pain? _____

Does it affect school, exercise or play, attitude/mood/sleep, decision-making/focus? (**Circle all that apply**)

Chiropractic History

Has your child ever been **adjusted**? Y N Doctor or Office's Name: _____

Last visit: _____ Duration of care: _____

Reason for visit: _____ Result: _____

Has your child ever has **Nutrition Response Testing**? Y N Doctor or Office's Name: _____

Reason for visit: _____ Result: _____

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Other Current Providers (Office and Doctor/provider name, last visit date and reason) _____

_____

Mom's Pregnancy/Birth (check all that apply) If adopted and no details are known please check here _____

___Tobacco ___Alcohol ___Medications ___ Recreational drugs ___Falls/injuries ___Abuse (any type)

___ Hospital ___Home ___Vaginal ___Cesarean (ER?) ___Vacuum ___Forceps

___Medications ___Epidural ___Complications Details: _____

Childhood (Age 0-13): (check all that apply)

Breast Fed: Yes No How Long? _____ **Formula Fed:** _____Dairy _____ Soy How Long? _____

Breastfeeding issues / Reason formula fed?_____

Age when **solids** were introduced: _____ **Food Allergies** Yes No _____

Food Sensitivities _____

Vaccine History: ___Full CDC schedule ___ Selective schedule ___ Delayed, Full schedule ___ None

Why? _____

Medications (type and reason): _____

Supplement (type, reason and who recommended): _____

Physical, emotional, or sexual abuse? Yes No **Nightmares or Night Terrors?** Yes No

Notes: _____

Crawled before walking? Yes No N/A **Shoulder or elbow dislocations?** Yes No

Played in a **hanging/bouncy swing** (Johnny Jump-Up)? Yes No Plays on a **trampoline**? Yes No

Can s/he currently: (mark all that apply) ___Sit Independently ___Crawl forward with opposite hand and knee ___ Stand Independently ___Walk Independently ___ Jump ___ Skip ___ Pinch ___Read ___ Write

Mark all that apply for current **bowel/bladder** trends: ___ diapers all day and night ___ diaper/ pull-up at night only

___ teaching Elimination Communication ___ enuresis (bed-wetting) ___ bowel movement at least once daily

Females: Menarche (1st menstrual cycle) Yes No If yes, Age: _____ Cramps/PMS? Yes No

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Health History

Mark any system or issue they have with ***(N) for Now or (P) for Past*** *(Including Birth until Now)*

___ Nervous System	___Prostate	___ Arthritis	___ Accidents/Falls/Injuries/Concussions
___ Musculoskeletal	___ Eyes	___ Sinuses/Allergies	___ Surgeries/Organ Removal
___ Digestive	___ Ears/Nose/Throat	___ Seizures	___ Fractures/Dislocations
___ Respiratory	___ Dental/Jaw issues	___Cancer	___ Cholesterol/Blood Pressure
___ Cardiovascular	___ Thyroid	___Stroke	___ Vaccine Medication Reaction
___ Immune	___ Adrenals	___ Scoliosis	___ Depression/Anxiety
___ Reproductive	___ Learning Difficulties	___ Anemia	___ Diabetes (Type:_____)
___ Bowels/Bladder	___ Headaches/Migraines	___ Dizziness/Vertigo	___ Significant Family History
___ Skin	___ Numbness/Tingling	___ Autism Spectrum Disorder	___ Colic

Other_____

Household Habits

Do you **filter** your drinking/cooking/shower water and/or air ? Yes No Do you eat **organic foods**? Yes No Mostly

Do you use **organic body products?** Yes No _____

Child's Diet / Mom's Diet if Breastfeeding include the following:

Dairy (milk, yogurt, cheese)	Yes No	Fast food	Yes No	Coffee	Yes No
Meat	Yes No	Water	Yes No	Alcohol	Yes No
Vegetables	Yes No	Caffeine	Yes No	Soda/Energy Drinks	Yes No
Fruit	Yes No	Tea	Yes No	Recreational drugs	Yes No
Gluten (flour, wheat, pasta)	Yes No	Juice	Yes No	OTC/prescription drugs	Yes No
Soy	Yes No	Sugar	Yes No	Tobacco	Yes No

Parent Signature: _____ Date: _____

Practitioner Name: _____ Date: _____

Practitioner Signature: _____

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HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Lotus of Life Chiropractic to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS: _____ I give permission to Lotus of Life Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

_____ If Lotus of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

_____ I give permission to Lotus of Life Chiropractic to use my name on a welcome board, referral board, and birthday board.

_____ I give permission to Lotus of Life Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

_____ I give permission to Lotus of Life Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

_____ I give Lotus of Life Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Lotus of Life Chiropractic permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Lotus of Life Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Lotus of Life Chiropractic. The written notice must contain the following information: Your name and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Lotus of Life Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Lotus of Life Chiropractic will not refuse to provide treatment however, it will not be possible for Lotus of Life Chiropractic to contact me to schedule appointments or discuss my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

DOB:_____

Participant's Name (please print):_____

Participant's Signature:_____

Today's Date:_____

Name of Personal Representative (if someone is designated to act on your behalf/or for minor)

Parent or Personal Representative's name (please print):_____

Signature:_____

Today's Date:_____