

PEDIATRIC HISTORY FORM

Today's Date: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

PATIENT DEMOGRAPHICS

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_ ☐ Male ☐ Female

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mother's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Father's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Father's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Pediatrician/Family MD: \_\_\_\_\_ City/State: \_\_\_\_\_

Last Visit Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Reason for visit: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

☐ Father's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

☐ Mother's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

☐ Father's Driver's License #: \_\_\_\_\_

☐ Mother's Driver's License #: \_\_\_\_\_

☐ 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. Has this problem occurred before? ☐ No ☐ Yes If yes, 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 yes**, whom? \_\_\_\_\_

5. How long ago? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

6. What were the results of past treatment? \_\_\_\_\_

7. How is this problem NOW?

☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On and Off

8. Please list any medication(s) taken for this problem: \_\_\_\_\_

9. Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes **If yes**, please explain: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes **If yes**, please explain:

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**HAS YOUR CHILD EVER SUFFERED FROM - Check all that apply**

- |  |  |  |   |
|--|--|--|---|
| <input type="radio"/> Headaches                | <input type="radio"/> Orthopedic Problems    | <input type="radio"/> Digestive Disorders        | <input type="radio"/> Behavioral Problems |
| <input type="radio"/> Dizziness                | <input type="radio"/> Neck Problems          | <input type="radio"/> Poor Appetite              | <input type="radio"/> ADD/ADHD            |
| <input type="radio"/> Fainting                 | <input type="radio"/> Arm Problems           | <input type="radio"/> Stomach Aches              | <input type="radio"/> Ruptures/Hernia     |
| <input type="radio"/> Seizures/Convulsions     | <input type="radio"/> Leg Problems           | <input type="radio"/> Reflux                     | <input type="radio"/> Muscle Pain         |
| <input type="radio"/> Heart Trouble            | <input type="radio"/> Joint Problems         | <input type="radio"/> Constipation               | <input type="radio"/> Growing Pains       |
| <input type="radio"/> Chronic Earaches         | <input type="radio"/> Backaches              | <input type="radio"/> Diarrhea                   | <input type="radio"/> Asthma              |
| <input type="radio"/> Sinus Trouble            | <input type="radio"/> Poor Posture           | <input type="radio"/> Hypertension               | <input type="radio"/> Walking Trouble     |
| <input type="radio"/> Scoliosis                | <input type="radio"/> Anemia                 | <input type="radio"/> Colds/Flu                  | <input type="radio"/> Sleeping Problems   |
| <input type="radio"/> Bed Wetting              | <input type="radio"/> Colic                  | <input type="radio"/> Broken Bones               | <input type="radio"/> Fall off swing      |
| <input type="radio"/> Fall in baby walker      | <input type="radio"/> Fall from bed or couch | <input type="radio"/> Fall from crib             | <input type="radio"/> Fall down stairs    |
| <input type="radio"/> Fall off bicycle         | <input type="radio"/> Fall from high chair   | <input type="radio"/> Fall off slide             |   |
| <input type="radio"/> Fall from changing table | <input type="radio"/> Fall off monkey bars   | <input type="radio"/> Fall off skateboard/skates |   |
| <input type="radio"/> Allergies to _____       |  |  |   |
| <input type="radio"/> Other: _____             |  |  |   |

I understand that I am directly and fully responsible to **Thompson Chiropractic** for all fees associated with 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 legal right to select and authorize health care services 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 this office.

\_\_\_\_\_  
**Parent or Legal Guardian's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Form Reviewed**

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

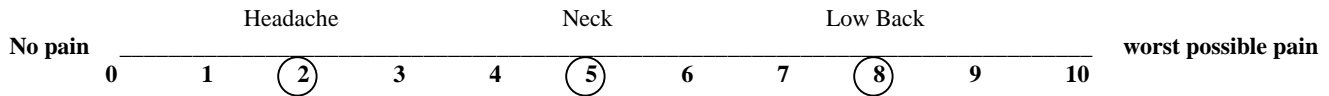
Date \_\_\_\_\_

**Please read carefully:**

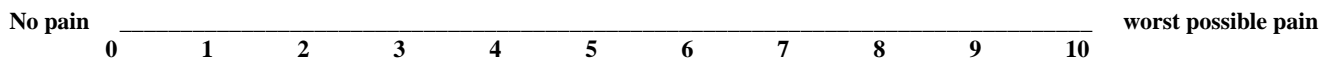
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

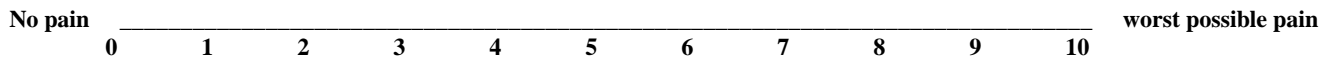
**Example:**



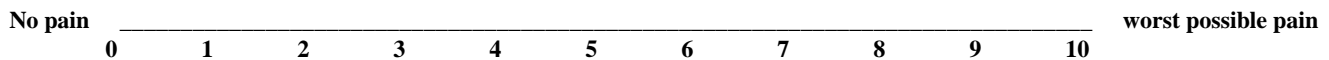
**1 – What is your pain RIGHT NOW?**



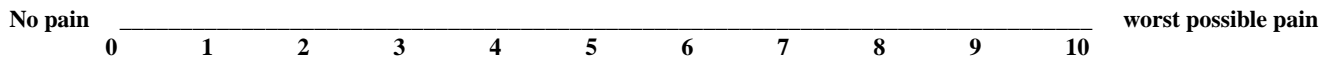
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## Thompson Chiropractic- Dr. Scot Thompson

### 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, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Thompson Chiropractic 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 any 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 Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

#### **REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY:** Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.

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

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

[Dr. Scot Thompson]  
[101 Hidden Glen Way Dothan, AL 36303]  
[drscotthompson.com]

[Thompson Chiropractic]  
[334-803-0803]  
[truth@drscotthompson.com]

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and 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 you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

#### YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

#### USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

#### COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights  
200 Independence Avenue, SW, Washington DC 20201  
877-696-6775  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

***NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...***

Please complete the following where indicated and return to our front desk staff.

Patient initials: \_\_\_\_\_ - retaining **page 1 of 2**

I hereby acknowledge I have read and received a copy of **Thompson Chiropractic** Privacy Practices Notice.

I understand my rights as well as the practice's 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 Practices" 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 the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

\_\_\_\_\_ Parent or guardian of minor patient

\_\_\_\_\_ Guardian or conservator of an incompetent patient

\_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## HIPAA Personal Health Information Release

I, \_\_\_\_\_, hereby authorize **Thompson Chiropractic** to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse                      Name: \_\_\_\_\_
- ☐ Significant Other              Name: \_\_\_\_\_
- ☐ Parent/Legal Guardian      Name: \_\_\_\_\_
- ☐ Child(ren)                      Name(s): \_\_\_\_\_
- ☐ Any Specified Person      Name: \_\_\_\_\_
- ☐ Information is not to be discussed with or released to anyone.

### Restrictions:

- ☐ No Restrictions
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

### Messages:

Please call      ☐ my home      ☐ my work      ☐ my cell phone

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ \_\_\_\_\_

I understand I may terminate this consent at any time by giving written notice to Thompson Chiropractic . Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## THOMPSON CHIROPRACTIC/DR. SCOT THOMPSON

### PATIENT TESTIMONIAL AND PHOTO RELEASE CONSENT

**Purpose of this Consent:** By signing this form, you are hereby consenting to allow THOMPSON CHIROPRACTIC and/or any of its associated staff members to use and distribute your photo, video and/or the information in your testimonial to the public.

I hereby grant permission to THOMPSON CHIROPRACTIC and/or staff to allow the use of my photograph, video and/or the information in my testimonial to be used in its public relations that may be distributed to the public. By granting this permission, I hereby agree and acknowledge that my photo, video and/or my testimonial may be released to the public via public relation efforts of THOMPSON CHIROPRACTIC. I further acknowledge and agree that my photo, video and/or my testimonial may be used by the media.

I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of THOMPSON CHIROPRACTIC. I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews as they arise.

I understand that I am providing my photo, video and/or my testimonial information to THOMPSON CHIROPRACTIC and that my treating healthcare provider will not be providing any information in my media records, the confidentiality of which may be protected by the federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I hereby waive the right of prior approval and hereby release THOMPSON CHIROPRACTIC from any and all claims for damages of any kind based on the use of my photo, video and/or my testimonial or information in my photo, video and/or the information in my testimonial. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my photo, video and/or my testimonial.

**Right to Revoke:** You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to THOMPSON CHIROPRACTIC. Please understand that revocation of this Release will not affect any action THOMPSON CHIROPRACTIC and/or staff took in reliance on this Release before receiving your revocation.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_