{Thompson Chiropractic}

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:

____

____

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

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

○ Allergies to ____

○ 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:

Headache Neck Low Back

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

---

1 – What is your pain RIGHT NOW?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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] **[Thompson Chiropractic]**
[101 Hidden Glen Way Dothan, AL 36303] [334-803-0803]
[drscotthompson.com] [truth@drscotthompson.coml]

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/

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.

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

Restrictions:

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

Messages:

Please call O my home O my work O my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- O you may leave a detailed message
- O please leave a message asking me to return your call
- O ____

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: ______________________________