Synchrony ChiroCare
Harmony of Structure and Function

Child's Case History

Please Print

Patient Information **Acct#_____**

_____
Child's Name Date of Birth

_____
Mother's Name Father's Name

_____
Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Mother's History

Tell me about your prenatal time:

a. Did you exercise? ○ Y ○ N Please explain: _____

b. Did you drink alcohol? ○ Y ○ N Please explain: _____

c. Did you take drugs? ○ Y ○ N Please explain: _____

d. Did you eat regularly? ○ Y ○ N Please explain: _____

e. Did you have any spinal pain or problems during your pregnancy?
○ Y ○ N Please explain: _____

Labor

a. How long was your labor? _____

b. Was labor artificially induced? ○ Y ○ N

c. Would you say it was: ? ○ Easy ○ Hard ○ Very Hard

d. Did you have a spinal block? ○ Y ○ N

e. How did you deliver the child?
○ On back ○ On all fours ○ Squatting ○ Sitting up in a birthing chair ○ Other _____

f. Did the doctor grasp/pull on child's head? ○ Y ○ N
Did you notice if the doctor twisted? ○ Y ○ N
Were forceps used? ○ Y ○ N

g. Do you remember the APGAR score? ○ Y ○ N If so, what was it?_____

h. Any complications? _____

_____

Baby's History

a. Was this child breastfed? ○ Y ○ N How long? _____

b. Did this child have any unusual or strange habits or behaviors as a newborn? _____

c. Colic? ○ Y ○ N

d. Fussy? ○ Y ○ N c. Alert? ○ Y ○ N d. Happy? ○ Y ○ N

e. Did child have shots (vaccinations)? ○ Y ○ N

f. Did child crawl? ○ Y ○ N Beginning at what age? _____ months

g. Was a child in a walker? ○ Y ○ N How long? _____

h. For how long did the child crawl? _____

i. At what age did child begin to walk? _____

j. Did you notice anything unusual about the child's efforts to learn to walk? ○ Y ○ N
Did the child fall a lot? ○ Y ○ N
Were there any particularly hard falls that you recall? ○ Y ○ N
If so, please explain: _____

Young Child

a. Ear infections? ○ Y ○ N

b. Colds? ○ Y ○ N

c. Mucus/sinus trouble? ○ Y ○ N

d. Falls? ○ Y ○ N

e. Collisions (Automobile)? ○ Y ○ N

Anything else you have noticed about your child that you think is unusual: _____

_____

_____

_____

_____

List any medications, past or present: _____

_____

_____

Any diagnosed diseases: _____

_____

_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

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Pain Diagram

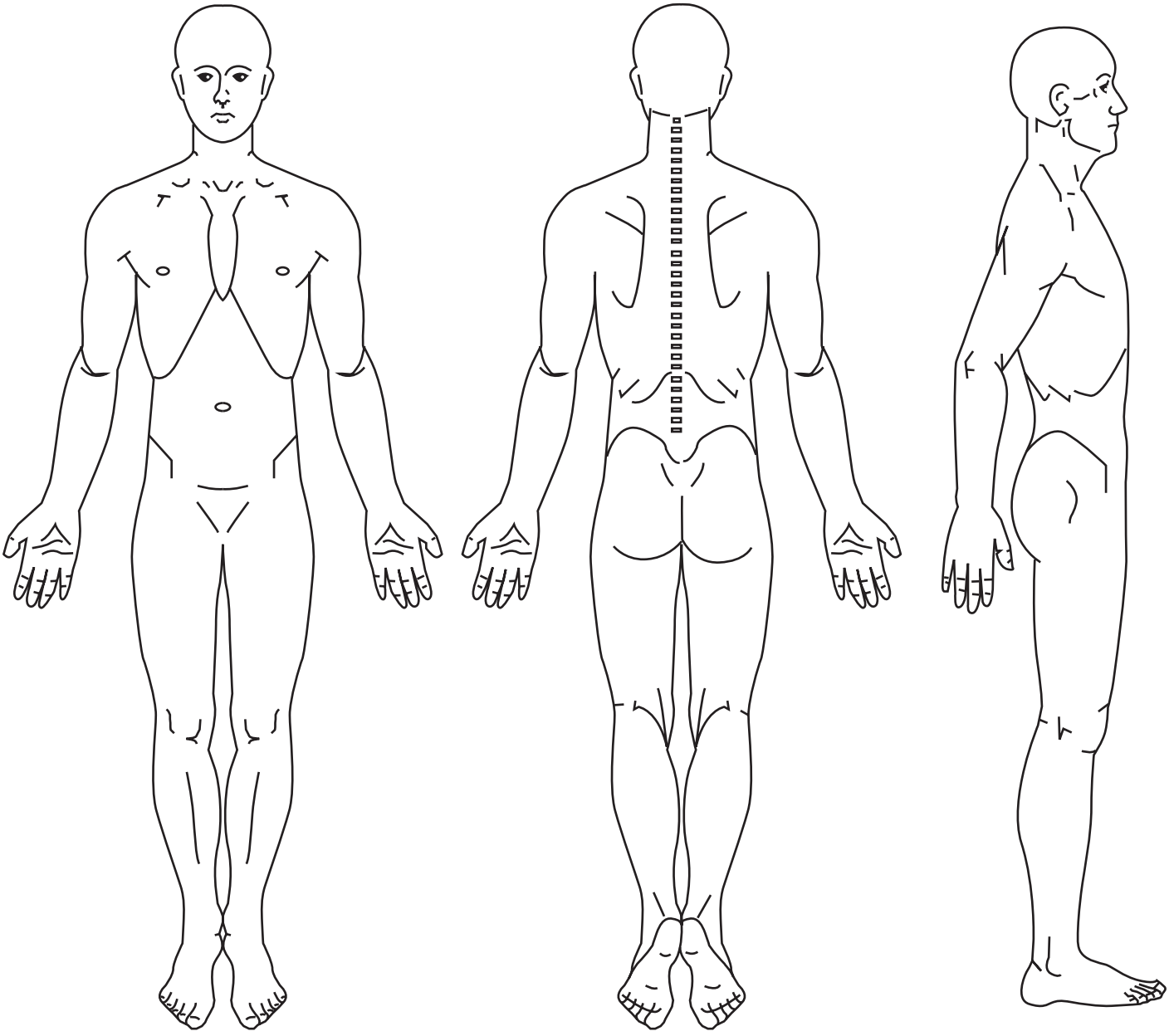
Please Print

Body Diagram Date _____ Acct# _____

Last Name _____ First Name _____

Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

X for Sharp Pain ***O*** Dull Ache /// Burning Pain *** Numbness



Patient's Signature _____ Date _____

Synchrony ChiroCare

Harmony of Structure and Function

Health Insurance Portability Accountability Act (HIPAA)

Health Care Information, Telephone Calls, and Open Room Treatment and Therapy

Dr. Michael Bennese and members of the Synchrony ChiroCare practice team may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Synchrony ChiroCare provides treatment and therapy in an open environment, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack there of may be discussed during your office visits.

Synchrony ChiroCare periodically randomly records (audio or video) selected doctor/patient communications. These recordings are used for quality control and training purposes only. By signing this form, you are giving us permission to periodically record communications you have with the doctor.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time, this is your right under Federal Law.

This notice is effective as of April 21, 2010. This authorization will expire seven years after the date in which you last received services from Synchrony ChiroCare.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient/Guardian Signature_____Date_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures as indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is not promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot pack and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is cause by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to on in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million person/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Print Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____