LA VIE CHIROPRACTIC **PEDIATRIC HISTORY FORM**

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2180 44th St. SE Ste. 209, Grand Rapids, MI 49508

Today's Date: _____/_____/_____

Name:_____ Date of Birth_____/_____/_____ Social Security # _____

Address:_____ City: _____ State: _____ Zip: _____

Phone (home) _____ Mother Cell:_____ Father Cell _____

Mother: _____ DOB ____/____/____ Father _____DOB____/____/_____

Pediatrician/Family MD _____ City and State _____ Last Visit: ___/___/_____

Purpose of last visit: _____

Birth Height: _____Birth Weight: ____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐Yes:

Who/When?_____

Who is responsible for this bill? ☐Mother ☐Father ☐ Other (please explain)_____

Insurance Company

_____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ____ Wellness ____ Check-up ____ Other: _____

____ Pain/Discomfort; explain: _____

____ Injury; explain: _____

If due to Pain/Discomfort/Injury, please fill out:

1. Onset of Problem: Date _____/_____/_____ ____ Unknown ____ Gradual ____ Sudden
2. **Ever had** this problem **before**? ☐ Yes ☐ No If yes, when? _____
3. Any **bowel or bladder** problems since this problem began?: ☐ Yes ☐ No (Describe): _____
4. Any **medication taken** for this problem? ☐ Yes ☐ No If yes, please list: _____
5. Have you seen any **other doctors** for this problem? ☐ Yes ☐ No If yes, please list: _____
6. How is this problem **NOW**: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

PREGNANCY HISTORY:

Third Trimester Presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Type of Birth: ☐ Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap or Vacuum

Location: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Problems during Pregnancy:_____

Problems during Labor/Delivery:_____

Was there presence of: ☐ Jaundice? (Yellow) ☐ Cyanosis? (Blue) ☐ Congenital Anomalies/Defects?

(*If yes, Please explain*) _____

INFANT HISTORY:

Infant feeding: ☐ Breast ☐ Bottle If bottle; which Formula? _____

Number of hours slept per night? _____ Quality of Sleep?: ☐ Good ☐ Fair ☐ Poor

List all **IMMUNIZATIONS** your child has had: _____

Has your child ever been treated at the emergency room? Y / N? If yes; please explain _____

Has your child ever been hospitalized? Y / N? If yes; please explain _____

Has your child ever had any surgeries? Y / N? If yes; please explain _____

Is your child currently on any medications? Y / N? If yes; please list _____

AT WHAT AGE DID THE CHILD:

Respond to sound ____ Follow an object with his/her eyes ____ Hold head up ____

Sit Alone ____ Crawl ____ Stand ____ Walk Alone ____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken Pox ____ Mumps ____ Measles ____ Rubella ____ Whooping Cough ____

Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appitite	☐ 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	☐ Diarreha	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall off from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _____

Has your child ever sustained an injury playing organized sports? Y / N? If yes, please explain

_____

Has your child ever sustained an injury in an auto accident? Y / N? If yes, please explain

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following:

Write "C" for child, "F" for family member:

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High/low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

I understand that I am directly and fully responsible to La Vie Chiropractic for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are the **sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than 7 years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter.
Client aggress that La Vie Chiropractic does not provide legal services, advice or counsel. Some advice, advertising and materials provided by La Vie Chiropractic may have legal implications. Client agrees to seek independent legal counsel before implementing said advice, advertising and materials. Client agrees to hold La Vie Chiropractic harmless from any legal taken by others against the client for any Client implementation that caused in whole or in part said legal action. Client assumes all liability and responsibility for client compliance to any State or Federal law, rule or their interpretation thereof by the governing authority.

Printed Name _____ Date _____

Signature _____

NOTICE OF HIPPA PRIVACY PRACTICE

La Vie Chiropractic 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 authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom of this page and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. 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 available 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 to 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-discussions with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders-we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. 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 mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to
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

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call La Vie Chiropractic at 616-464-0800. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

2180 44th St. SE Ste. 209

Grand Rapids, MI 49508

Note: 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 have received a copy of La Vie Chiropractic Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ (Patient Signature) _____ (Date)

_____ (Witness Signature) _____ (Date)