Sloan Family Chiropractic, P.S.
911 5th Ave SE, Suite 202
Olympia WA 98501
Phone: 360.956.3900
Fax: 360.956.3903

PEDIATRIC HISTORY FORM

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name_____ SSN_____
Birth Date_____ Sex_____ Weight_____ Height_____
Name of Parents/Guardian_____
Address_____
City_____ State_____ Zip_____
Phone #_____ Work #_____ Emergency #_____
Purpose for contacting us?_____
Other doctors seen for this condition? Y / N
Doctor's names and prior treatment:_____
_____
Other health problems?_____
Family history:_____
Previous chiropractor_____
Date of last visit_____ Reason_____
Name of Pediatrician_____
Date of last visit_____ Reason_____
Are you satisfied with the care your child has received there? Y / N
Number of doses of ANTIBIOTICS your child has taken:
During the last 6 months_____ Total during his/her lifetime_____
Number of doses of OTHER PRESCRIPTION MEDICATIONS your child has taken:
During the last 6 months_____ Total during his/her lifetime_____

Vaccination history_____

PRENATAL HISTORY

Name of obstetrician/midwife_____
Complications during pregnancy? Y / N List_____
Complications during delivery? Y / N List_____
Ultrasounds during pregnancy? Y / N List_____
Medications during pregnancy/delivery? Y / N _____
Location of birth __ Hospital __Birthing center __Home
Birth Interventions __Forceps __Vacuum Extraction __C-Section, Emergency/planned?
Genetic disorders or disabilities? Y / N List_____
Birth Weight_____ Birth Length_____

FEEDING HISTORY

Breastfed? Y / N How long?_____ Complications?_____
Formula fed? Y / N How long?_____ Type_____

Introduced: Solids at _____ months Cows mild at _____ months
Food/Juice allergies or intolerances? Y / N List_____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection so vertebral subluxation (Spinal Nerve Interference). At what age was your child able to:

_____Respond to sound
_____Respond to visual stimuli
_____Hold head up
_____Sit up
_____Cross Crawl
_____Stand alone
_____Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.).
Was this the case with your child? Y / N

Is or has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheer-leading, martial arts, track, etc.)? Y / N

Has your child ever been involved in a car accident? Y / N List_____

Has your child been seen on an emergency basis? Y / N List_____

Other traumas not described above? Y / N List_____

Prior surgery? Y / N List_____

Menarche? Y / N Age_____

CHILDHOOD DISEASES

Chicken Pox	Y / N Age_____	Mumps	Y / N Age_____
Rubella	Y / N Age_____	Whooping Cough	Y / N Age_____
Rubeola	Y / N Age_____	Other	Y / N Age_____

WE ARE HEARE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT AND FEES CHARGED BY THIS OFFICE.

Name of insurance company_____ Policy #_____

Signed_____ Witnessed_____ **Date**_____

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Financial Responsibility Statement

1. I understand and agree that insurance policies are an arrangment between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.

2. I understand that Sloan Family Chiropractic, P.S. will prepare any necessary reports and forms to assist me in making collection for the insurance company.

3. I understand that any amount authorized will be paid directly to Sloan Family Chiropractic and will be credited to my account upon receipt.

4. I authorize Sloan Family Chiropractic to release any information regarding my care at Sloan Family Chiropractic to my insurance company that will assist in the payment of the claim.

5. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment

Patient's Signature_____ Date_____
Print Name_____

Patient Name_____

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Patient Privacy Notice

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

How medical information about you may be used and disclosed and how you can access this information.

We are required by law to have your written consent before we use or disclose to other your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.
As our patient, you have important rights relating to inspecting and copying medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if you think your rights have been violated.
We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date, January 3, 2006, at the top right hand side of this page indicates the date of the most current Notice in effect.
You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.
If you have any questions, concerns or complaints about the Notice or your medical information, please contact: Drs. Heather & David Sloan, D.C. in our office at Sloan Family Chiropractic, P.S. Olympia, WA 98501 (360)956-3900.

Patient's Signature_____
Print Name_____

Patient Name_____

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other then vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I, _____ have read and fully understand the above statments. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Patient's Signature_____ Date_____
Print Name_____

Patient Name_____

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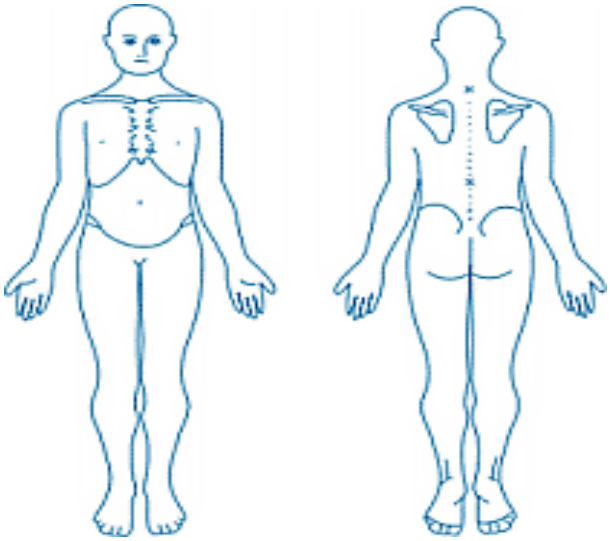
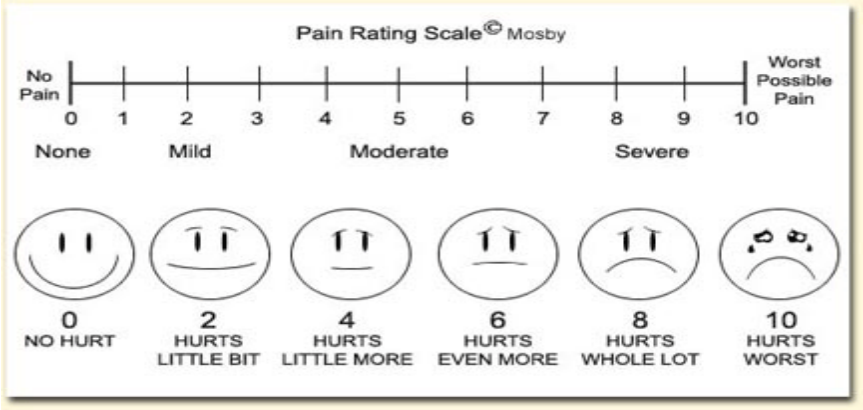
PAIN SCALE

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please color in the area on the diagram below and label accordingly.

SP= Sharp Pain DP= Dull Pain B= Burning S= Stinging
N= Numbness T= Tingling ST= Stiffness A= Abnormal Sensation



Pain Scale: Please circle the number below that best describes your current pain and draw a line (or number that region) to the diagram above.



Patient Name_____ Date_____