**Masterson Chiropractic Clinic**
**725 E. Market St.**
**Warsaw, IN 46580**
**Pediatric History (0-12 Years)**

**Patient Name _____________________________ Social Security # _______________**

**Parent or Guardian_______________________________________________________**

**Address_________________________ City___________ State_____ Zip___________**

**Home Phone #_____________________ Cell Phone #__________________________**

**Male___ Female ___ Birth date______________ Age ______**

**How were you referred to our office? ______________________________________**

**Purpose of this appointment_______________________________________________**

**Date symptoms appeared or accident happened_______________________________**

**Has your child ever had the same or a similar condition ___Yes ___ No**

**If yes, when and describe__________________________________________________**

**List all therapies undergone for this complaint (including medication)**

**_______________________________________________________________________**

**_______________________________________________________________________**

**Duration of pregnancy ____________weeks**

**Pregnancy normal Yes No**

**List any complications of delivery__________________________________________**

**_______________________________________________________________________**

**List any medications taken**

**During pregnancy_____________________________________________________**

**During delivery______________________________________________________**

**Was the infant alert and responsive within 12 hours of birth Yes No If no, please explain**

**_______________________________________________________________________**

**Breastfed Y or N How many months breastfed ____________**

**Formula given Y or N at what age started __________ Number of months given formula_______________**

**Intolerances/allergies_____________________________________________________**

**_______________________________________________________________________**

**Does the child's social behavior appear normal for age Yes No**

**If no please explain_______________________________________________________**

**_______________________________________________________________________**

**Has your child ever experienced any of the following:**

**Y N Chickenpox (age_____)**

**Y N Mumps (age_____)**

**Y N Measles (age_____)**

**Y N Rubella (age_____)**

**Y N Whooping Cough (age_____)**

**Y N Hyperactivity (age_____)**

**Y N Attention Deficit Disorder (age diagnosed_____)**

**Y N Learning Disability (age diagnosed_____)**

**Y N Digestive problems (age began_____)**

**Y N Hypoglycemia (age diagnosed_____)**

**Y N Diabetes (age diagnosed______)**

**Y N Bed-wetting (resolved Y N )**

**Y N Nosebleeds (resolved Y N )**

**Y N Asthma (age began_____)**

**Y N Headaches (age began_____)**

**Y N Colds/Flu**

**Y N HIV (age diagnosed_____)**

**Y N Hay fever (age began_____)**

**Y N Arm or Leg Pain/Tingling (age began_____)**

**Y N Arthritis (age began _____)**

**Y N Poor posture**

**Y N Scoliosis**

**Y N Drug addiction (when began______ How long_______ Substance__________**

**Y N Drug abuse (substance_______________________________________________)**

**Y N Immunizations (Please list type and age received):______________________**

**_________________________________________________________________________**

**Young ladies only:**

**Onset of Menstruation (age___________)**

**Is there any of the following:**

**Cramping Yes No**

**Vaginal Discharge Yes No**

**Fluid Retention Yes No**

**Please list any other significant data (i.e. hospitalizations, surgeries, accidents, traumas, current medications) ______________________________________________________________________**

**Authorization for physician to treat**

**I hereby authorize the chiropractic physicians of Masterson Chiropractic Clinic and whomever they may designate to administer care as they deem necessary to my child.**

**Parent or Guardian _____________________________________Date_____________**

# Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services or charitable work performed by our office. You may choose to opt-out of any marking or fundraising communications at this time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.

10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient ______________________________Date ___________________