Today's Date _____ Patient ID# _____

Pediatric Paperwork (0-15 years)

LOCKHART CHIROPRACTIC

Welcome to Our Office!

Please fill out our Health Record as complete and accurate as possible. If you have any questions, please don't hesitate to ask. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with chiropractic care.

Child's First Name: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Parent's Cell Phone: _____ Home Phone: _____
Parent's E-Mail: _____ Child's Birthday: _____
Gender: ○ Male ○ Female ○ Other
Who Referred you to this office? _____

Emergency Contact

First Name: _____ Last Name: _____
Phone Number: _____ Relationship: _____

Health Insurance

Insurance Company: _____
Policy #: _____ Group: _____

About The Insured Person (If Not-Self)

Insured's First Name: _____ Insured's Last Name: _____
Insured's Relation: _____ Insured's Date of Birth: _____

Primary Complaint

(Please list one area for each complaint i.e. neck pain and headaches for primary complaint and low back pain for second complaint)

Where is your child's primary problem located? _____
How did this problem begin? _____
When did this condition begin? _____

Overall frequency of complaint
(please check only one)
- ○ Constant (100% of the time)
- ○ Frequent (51-75%)
- ○ Occasional (26-50%)
- ○ Intermittent (1-25%)

How intense is pain/symptoms?
○ No pain ○ Mild ○ Mild-Moderate ○ Moderate ○ Mild-Moderate ○ Severe

If they report pain, how do they describe it?

- ○ aching
- ○ burning
- ○ dull
- ○ heavy
- ○ pulling/spasm
- ○ numb
- ○ sharp
- ○ stiffness
- ○ throbbing
- ○ tightness
- ○ tingling

Does this problem travel to any other area of your child's body? If yes, please explain:

_____

What makes the problem better? _____

What makes the problem worse? _____

Has this condition
○ gotten worse ○ stayed the same ○ gotten better

Have you seen other doctors/medical providers for this condition?
○ yes ○ no

Doctor/Provider's Name(s) _____

Type of Treatment: _____

Has any imaging or diagnostic testing been done? (i.e. X-Ray, MRI, EMG)
○ yes ○ no

Has this condition occurred before?
○ yes ○ no

Secondary Complaint

(Please list one area for each complaint i.e. neck pain and headaches for primary complaint and low back pain for second complaint)

Where is your child's secondary problem located? _____

How did this problem begin? _____

When did this condition begin? _____

Overall frequency of complaint
(please check only one)
- o Constant (100% of the time)
- o Frequent (51-75%)
- o Occasional (26-50%)
- o Intermittent (1-25%)

How intense is pain/symptoms?
○ No pain ○ Mild ○ Mild-Moderate ○ Moderate ○ Mild-Moderate ○ Severe

If they report pain, how do they describe it

- ○ aching
- ○ burning
- ○ dull
- ○ heavy
- ○ pulling/spasm
- ○ numb
- ○ sharp
- ○ stiffness
- ○ throbbing
- ○ tightness
- ○ tingling

Does this problem travel to any other area of your child's body? If yes, please explain:

_____

What makes the problem better? _____

What makes the problem worse? _____

Has this condition
○ gotten worse ○ stayed the same ○ gotten better

Have you seen other doctors/medical providers for this condition?
○ yes ○ no

Doctor/Provider's Name(s) _____

Type of Treatment: _____

Has any imaging or diagnostic testing been done? (i.e. X-Ray, MRI, EMG)
○ yes ○ no

Has this condition occurred before?
○ yes ○ no

Medical History

Has your child had any surgeries?
○ yes ○ no

Please list surgeries and year:
_____

Has your child been hospitalized?
○ yes ○ no

Please list when your child was hospitalized and the reason:
_____

Has your child been in any previous Accidents or traumatic events?
○ yes ○ no

Please list type of trauma and year:
_____

Does your child have a primary care provider/pediatrician?
○ yes ○ no

Please list primary care provider and location:
_____

Please list any prescribed medications:
_____

Does your child have any family history of cancer, diabetes, heart disease, stroke, spinal disorders, neurological conditions, or connective tissue disorders?
○ yes ○ no

Please list family member and condition
_____

Does your child exercise regularly?
○ daily ○ few times/week
○ weekly ○ no

Is your child on a special diet?
○ yes ○ no

Health Conditions

Musculoskeletal

○ No musculoskeletal complaints
○ Ankle Pain
○ Connective Tissue Disorder
○ Elbow Pain
○ Fracture
○ Growing Pains
○ Hip Pain
○ Knee Pain
○ Scoliosis
○ Shoulder Pain
○ Torticollis
○ TMJ Pain
○ Wrist and/or Hand Pain

Neurological

○ No Neurological Complaints
○ ADD/ADHD
○ Anxiety Disorder
○ Autism
○ Colic
○ Depression
○ Dizziness
○ Frequent Crying Spells
○ Headache/Migraine
○ Night Terrors
○ Pinched Nerve
○ Sleeping Issues
○ Weakness
○ Seizures

Head (Ears, Nose, and Throat)

○ No Head/ENT Complaints	○ Tonsillitis	○ Change in head dimensions	○ Chronic ear infections
○ Chronic Ear Infections	○ Blurred/double Vision	○ Eyeglasses/Contacts	○ Nose Congestion
○ Frequent Colds/Croup	○ Dental/Gum Problems	○ Ringing in the ears	
○ Sore Throat	○ Nose congestions/sinus problems	○ Sore throat	

Cardiovascular

○ No cardiovascular complaints	○ Arrhythmia/irregular heartbeat	○ Blood clots
○ Chest pain/tightness	○ Congenital heart defect	
○ Shortness of Breath	○ Heart Murmur	

Respiratory

○ No respiratory complaints	○ Asthma	○ Hay Fever	○ Persistent Cough
○ Pneumonia	○ Shortness of Breath	○ Wheezing	

Gastrointestinal

○ No gastrointestinal complaints	○ Abdominal pain	○ Black/bloody stools
○ Change in bowel habits	○ Constipation	○ Difficulty swallowing
○ Failure to thrive/slow weight gain	○ Food Sensitivities	○ Irritable Bowel Syndrome
○ Liver disease	○ Nausea/vomiting	○ Severe Diarrhea
○ Trouble nursing		○ Liver disease

Genitourinary

○ No genitourinary complaints	○ Bedwetting	○ Blood in urine
○ Painful or frequent urination	○ Urinary tract infections	○ Incontinence

Endocrine

○ No endocrine complaints	○ Diabetes	○ Feeling hot or cold
○ Pancreatic condition	○ Steroid Treatment	○ Increased urination

Dermatological/Hematological

○ No derm/hematological complaints	○ Blood in stool	○ Change in hair/nails
○ Easy bruising	○ Eczema	○ Excessive acne
○ Hyper/hypo Pigmentation	○ Psoriasis	○ Skin trouble/rashes

I consent to a professional and complete chiropractic examination and to any radiographic examinations that the doctor deems necessary. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

_____ _____

Patient/Parent/Guardian Signature Date

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

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

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that unlike many other health care professions, the risk associated in receiving chiropractic care is extremely minimal. In recent years there have been rare incidents or injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. 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. Please discuss care alternatives with the attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At Lockhart Chiropractic, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I _____ have fully read and understand the above statement.
(PRINT PATIENT'S NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Edward Lockhart III or other attending chiropractors.

_____

(SIGNATURE) (DATE) (WITNESS)

CONSENT TO ASSESS AND ADJUST A MINOR:

I _____ , being the parent or legal guardian of _____ have
(PARENT/GUARDIAN NAME) (CHILD'S NAME)

read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

Notice of Privacy Practices (HIPAA)

LOCKHART CHIROPRACTIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Heath Information" is information about you, including demographic information that may identify you and that relate to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to your when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may review this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

I authorize any representative from Lockhart Chiropractic to discuss or release information regarding my care and billing:

○ Full Access ○ Declined

With the following individual(s): _____

Patient Name: _____ Date: _____

Patient Signature: _____

Social Media/Reminder/Marketing Authorization and Releases

The Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my Protected Health Information. I hereby give permission to Lockhart Chiropractic to use and/or disclose Protected Health Information in accordance with the following *(cross off any you do not give consent for)*:

Specific Authorizations:

- I give permission to Lockhart Chiropractic to use my address, phone number, e-mail address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Lockhart Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine/voicemail or with the person who answers the telephone at home, work, or cell number I have provided.
- I give permission to Lockhart Chiropractic to use my name on a welcome board, referral board and birthday board.
- I give permission to Lockhart Chiropractic to use my photograph on their waiting room slideshow, patient of the month gallery and other marketing materials such as their brochure, website, social media and ads in print media.
- I give permission to Lockhart Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on social media, patient of the month gallery and ads in print media.
- I give Lockhart Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Lockhart Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Lockhart Chiropractic plus 7 years or until revoked by me.

I have read and consent to the Lockhart Chiropractic's Specific Authorization policies.

_____ _____

Patient Signature Date

Office Policies

LOCKHART CHIROPRACTIC

Cancellation/No-Show Policy: We are committed to offering the best service to everyone who needs our services. Therefore, we require a minimum 24-hour cancellation notice on all appointments, unless in cases of emergency. **We will bill you $55 for each missed appointment if not cancelled within 24 hours (at doctor's discretion).**

Late & Rescheduling: Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Need Extra Time?: If you think of other problems you wish us to work on during your appointment, please let us know and we will be happy to schedule additional time for your next appointment.

Insurance: Your insurance is an agreement between you and your insurance company. We offer complimentary benefits check to verify coverage; however, the **benefits quoted to us by your insurance company are not a guarantee of payment**. You are responsible for payment of any non-covered services, deductibles or co-pays. Please notify us if your carrier or policy has changed.

Non-Participating or "Out of Network:" It is the responsibility of the patient to verify whether Lockhart Chiropractic contracts with your insurance plan. Any outstanding balances are the responsibility of the patient.

Account Balance: Unless Lockhart Chiropractic has an active financial payment agreement on file for you, *account balances may not exceed $200.00.*

Self-Pay/Uninsured: We understand not everyone has chiropractic coverage. A discount can be applied when you pay on the same day as the treatment given, but not to supplies used. *Once the discount is given, it cannot be billed to an insurance company.*

Injury/Worker's Compensation: If your condition is due to an injury, please let us know on your first visit in the clinic and give us any billing information. If we do not receive the billing information on your first visit, the full amount will become your responsibility. We do not accept third party billing or attorney assignments

I have read, understand, and agree to Lockhart Chiropractic Clinic's Office Policies.

Patient Signature _____ Date _____