



PEDIATRIC HISTORY FORM

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy Integrative Physical Medicine patients. We look forward to working with you to build better health for your family.

Patient Information:

Name: _____ S.S. #: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Ph: _____
Birth Date: _____ Sex: M F Weight: _____ Height: _____
Referred By: _____

Parent/Guardian Information:

Name(s): _____
Cell Ph: _____ Work Ph: _____
Birth Date: _____ S.S. #: _____

Purpose for Contacting Us?

Have you seen other doctors for this condition? ___N ___Y

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from during the Past Six Month:

___ Ear Infections ___ Scoliosis ___ Seizures ___ Colds
___ Headaches ___ Asthma/Allergies ___ Digestive Problems ___ ADHD
___ Recurring Fevers ___ Colic ___ Growing/Back Pain ___ Bed Wetting
___ Car Accident ___ Temper Tantrums Other: _____

Family History/ Health Problems? _____

Previous Chiropractor: _____ Date of Last Visit: _____

Number of Doses of Antibiotics Your Child has Taken:

During the Past 6 Months: _____, During Last Year: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past 6 Months: _____, During Last Year: _____

Number of Doses of Over-the-Counter Medications Your Child has Taken:

During the past 6 Months: _____, During Last Year: _____

Prenatal History:

Complication During Pregnancy? ___ N ___ Y

List: _____

Medications During Pregnancy/Delivery? ___ N ___ Y,

List: _____

Location of Birth: ___ Hospital ___ Birth Center ___ Home

Birth Intervention: ___ Forceps ___ Vacuum Extraction ___ Caesarian Section

Complications During Delivery? ___ N ___ Y,

List: _____

Genetic Disorders or Disabilities? ___ N ___ Y,

List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed? ___ N ___ Y How Long: _____

Formula Fed? ___ N ___ Y How Long: _____

Developmental History:

Please list any falls your child has had in the past (i.e. form changing tables, stairs, bed, bike, tube, etc.)

1. _____
2. _____
3. _____

Is/has your child been involved in any impact or contact type sports (i.e., Soccer Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ___ N ___ Y

List Details: _____

Has Your Child Ever Been Involved in a Car Accident Over 3mph? ___ N ___ Y, When: _____

List Details: _____

Has Your Child Been Seen on an Emergency Basis? ___ N ___ Y

List Details: _____

Other Traumas Not Described Above? ___ N ___ Y, List Details: _____

Prior Surgery? ___ N ___ Y, List Details: _____

Childhood Diseases:

Chicken Pox	N	Y, Age _____	Mumps	N	Y, Age _____
Rubella	N	Y, Age _____	Whooping Cough	N	Y, Age _____
Rubeola	N	Y, Age _____	Other	N	Y, Age _____

Please list all others: _____

Other Information:

What percentage (%) of the day does your child..

___ play outside or exercise?

___ play video games/watch TV/play on computer?

___ engage in activities? (church, sports, school, etc.) Please List: _____

Rate your child's food intake: 1 2 3 4 5 6 7 8 9 10
(Poor – Processed Foods/TakeOut/Fast Food) to (Organic, Fresh, Healthy)

Rate your child's school performance: 1 2 3 4 5 6 7 8 9 10
(Poor) (Average) (Outstanding)

What could improve? _____

How many days per year does your child miss school due to illness? 0 1-2 3-6 7 or more

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 of all fees charged by this office at time that services are rendered.

Name of Insurance Company: _____ Policy #: _____

Print Name: _____ Signature: _____ Date: _____

Food Tolerance Survey

Patient Name _____ Date _____

Please complete the following food and chemical sensitivity questionnaire. Mark each symptom based upon your experiences over the last 60 days. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:

- = **No** Symptoms
- = Experience Mild Symptoms
- = Experience Moderate Symptoms
- = Severe Symptoms

Digestive Symptoms

- 0000 Stomach Pains or Cramping
- 0000 Constipation
- 0000 Diarrhea
- 0000 Reflux of Heartburn
- 0000 Bloating
- 0000 Gas
- 0000 Nausea or Vomiting

Weight

- 0000 Inability to Lose Weight
- 0000 Food Cravings
- 0000 Binge Eating
- 0000 Water Retention

Sinus Respiratory

- 0000 Stuffy or Runny Nose
- 0000 Asthma
- 0000 Chest Congestion
- 0000 Chronic Cough
- 0000 Wheezing
- 0000 Frequent Sneezing

Head/Ears

- 0000 Migraines
- 0000 Headaches
- 0000 Earaches
- 0000 Ear Infections
- 0000 Ringing in Ears

Eyes & Throat

- 0000 Itchy eyes
- 0000 Watery Eyes
- 0000 Sore Throat
- 0000 Persistent Canker Sores

Emotional/Mental

- 0000 Depression
- 0000 Anxiety
- 0000 Mood Swings
- 0000 Irritability
- 0000 Poor Concentration

Energy

- 0000 Fatigue
- 0000 Hyperactivity
- 0000 Lethargy
- 0000 Restlessness
- 0000 Insomnia

Skin Disorders

- 0000 Eczema
- 0000 Dermatitis
- 0000 Excessive Sweating
- 0000 Rashes
- 0000 Hives

Other Symptoms

- 0000 Joint Pain
- 0000 Arthritis
- 0000 Irregular Heartbeat
- 0000 Chest Pains
- 0000 Muscle Aches

Please list any symptoms not mentioned above: _____



425 Alexandria Blvd, Suite 1010, Oviedo FL, 32765
NPI# [1588974992](#)

HIPPA Practice Requirements

The Practice:

- a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- c) Is required to abide by the terms of this Privacy Notice.
- d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- e) Will distribute a revised Privacy Notice to you prior to implementation.
- f) Will not retaliate against you for filing a complaint.

Effective Date

This Notice is in effect as of 04/15/2003

State Law

A copy of the state HIPAA laws will be available to me at any time for my review, and a copy will be given to me upon my request.

Patient Acknowledgement

By signing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

Patient Signature: _____

Date: _____ / _____ / _____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

Patient's Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

Integrative Physical Medicine
425 Alexandria Blvd, Suite 1010, Oviedo FL, 32765
Phone: 407-977-3434 ♦ Fax: 407-977-3433

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Integrative Physical Medicine.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Integrative Physical Medicine to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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: The 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 diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, 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 another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.