Pediatric Member Forms

It is a pleasure to welcome you to our family of happy and healthy practice members of Keystone Chiropractic. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors can interfere with your child's growing brain, spine, and nervous system. 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.

Child's Name: _____ Date: _____

Age: _____ ☐ Male ☐ Female Birthday: _____ Weight: _____ lbs. Height: _____ ft. _____ in.

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian: _____

Home phone: _____ Cell phone: _____

Cell Phone Provider: ☐ Verizon ☐ AT&T ☐ T-Mobile ☐ Sprint ☐ Other: _____

E-mail: _____

How did you hear about Keystone Chiropractic? _____

Who may we thank for referring you? _____

Reason for pursuing care: ☐ Maintenance ☐ Improve health ☐ Problem: _____

Family history: _____

Check any of the following conditions that currently apply:

☐ Ear infections	☐ Scoliosis	☐ Chronic colds	☐ Headaches
☐ Digestive problems	☐ Allergies	☐ ADD/ADHD	☐ Recurring fevers
☐ Growing pains	☐ Colic	☐ Seizures	☐ Temper tantrums
☐ Bed wetting	☐ Asthma	☐ Car accident: When? _____	
☐ Other: _____		☐ Other: _____	

Other doctors seen for this condition (Please include doctor's names and prior treatment):

_____

Previous Chiropractic Care? ☐ Yes ☐ No Date of last visit: _____

Name of Pediatrician: _____ Date of last visit _____

Are you satisfied with the care your child has received at the pediatrician? ☐ Yes ☐ No

# of Doses of antibiotics your child has taken: Past 6 months _____ Total lifetime _____

Current prescription drugs & dosage: _____

Past prescription drugs & dosage: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.): _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy/delivery? ☐ Yes ☐ No Explain: _____

Ultrasounds during pregnancy? ☐ Yes ☐ No How many? _____

Medications taken during pregnancy/delivery? ☐ Yes ☐ No List: _____

Cigarette/Alcohol use during pregnancy? ☐ Yes ☐ No

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section

If Caesarian Section, was it: ☐ Emergency ☐ Planned

Genetic disorders/disabilities? ☐ Yes ☐ No List:_____

Birth Weight:_____ Birth Height:_____ APGAR Scores: _____ - _____

Feeding History

Breast Fed: ☐ Yes ☐ No How long? _____

Formula Fed: ☐ Yes ☐ No How long? _____ Type: _____

Introduced to: Solid Foods @ _____ months Cow's milk @ _____ months

Food/Juice allergies or intolerances: ☐ Yes ☐ No List: _____

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of neuro-structural shifts. The following can be affected by neuro-structural shifts. At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone _____ Sit up

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did your child have a fall similar to what was described above?

☐ Yes ☐ No Explain: _____

Other traumas not described above (bike fall, trampoline injury, etc.)?

_____

Has your child been involved in any sports? ☐ Yes ☐ No

List: _____

Has your child been seen by a physician on an emergency basis? ☐ Yes ☐ No Explain: _____

Lifestyle (please check all that apply):

Does your child: ☐ Eat healthy food (organic products, etc.) ☐ Drink water

☐ Take probiotics ☐ Take vitamins Type: _____

Exercise: ☐ none ☐ mild ☐ moderate ☐ heavy ☐ daily

Hobbies/ interests: _____

Is there anything else you would like us to know about your child? _____

_____

By signing below, I am acknowledging that I am a parent/guardian of the above child, and I have filled out all the above accurately and to the best of my ability.

*Print Name*_____ *Signature*_____ *Date* _____

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.
For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Keystone Chiropractic, or anyone authorized by Keystone Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Keystone Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Keystone Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

*Parent/Guardian Signature*_____ *Date* _____

Notice of Privacy Practices Acknowledgement
This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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 dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.
Permitted Disclosures:

- Treatment purposes – discussion with other health care providers involved in your care
- Inadvertent disclosures – open treating area means 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
- For payment purposes – to obtain payment from your insurance company or any other collateral source
- For worker's compensation purposes – to process a claim or aid in investigation
- Emergency – in the event of a medical emergency, we may notify a family member
- For public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
- To governmental agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person
- For military, national security, prisoner, and government benefits purposes
- Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
- Telephone calls or emails and appointment reminders – we may call your home/cell and leave voice/text messages regarding an appointment, a missed appointment, or notify you of changes in practice hours or upcoming events
- Announcing names in queue at the front desk & reception area – we announce the first and last names of patients in queue that are waiting to be treated (eg. "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed
- Change of ownership – in the event this practice is sold, the new owners would have access to your Personal Health Information

Your rights:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive Detail Privacy Notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neuro-structural shift.
- The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctors of chiropractic in the United States alone.
- Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

Informed Consent For Chiropractic Care

Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is often very minimal. Yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below:

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Dr. Joshua Baek and/or Dr. Daniel Baek. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Name of Practice Member Who is a Minor/Child:*_____

- I authorize Dr. Joshua Baek and/or Dr. Daniel Baek, and any and all Keystone Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Keystone Chiropractic.

*Parent/Guardian Signature*_____ *Date* _____

X-Ray Authorization

As your health care provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day.

Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Keystone Chiropractic do not diagnose or treat medical conditions. However, the doctors will refer questionable x-rays films to be interpreted by a radiologist hired by Keystone Chiropractic. The radiologist will submit a report of their interpretation to Keystone Chiropractic, and if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC STRUCTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

Child's name _____ Child's age _____

*Parent/Guardian Signature*_____ *Date* _____

By signing below, I am agreeing to the Notice of Privacy Practices Acknowledgement, Terms of Acceptance, and all the terms and conditions above.

*Print Name*_____ *Signature*_____ *Date* _____