Frederick Chiropractic Wellness Center

Dr. Deborah Morrone

425 E. Patrick Street, Frederick, MD 21701 • 301-695-0032

www.frederickchiro.com

CHILDS NAME ______________________________ MOTHERS NAME ____________________ DOB ____________

ADDRESS ______________________________ FATHERS NAME ____________________ DOB ____________

CITY/STATE/ZIP ______________________________ PHONE (H) ________________ (W) ______________

DOB ________________ AGE ______________ (C) ________________ EMAIL ______________________

OF SIBLINGS _______ AGES __________________ REFERRED BY ____________________________________

HEALTH HISTORY

THIRD TRIMESTER PRESENTATION VERTEX BREECH TRANSVERSE FACE/BROW

TYPE OF BIRTH NORMAL VAGINAL FORCEPS CESAREAN VACUUM/SUCTION CAP INDUCED

LOCATION HOME BIRTHING CENTER HOSPITAL NAME ____

OBSTETRICIAN/MIDWIFE __________________________ PEDIATRICIAN/FAMILY DR ________________________________

PROBLEMS DURING PREGNANCY ____

PROBLEMS DURING LABOR/DELIVERY ____

APGAR SCORES __________/__________ WAS THERE JAUNDICE (YELLOW) CYANOSIS (BLUE)?

CONGENITAL ANOMALIES/DEFECTS? Y N IF YES, EXPLAIN? ____

INFANT FEEDING BREAST BOTTLE IF BOTTLE, WHAT TYPE OF FORMULA? ____________________________________

AT WHAT AGE WERE SOLID FOODS STARTED? __________ FOOD ALLERGIES/INTOLERANCES? ___________________________

AT WHAT AGE DID YOUR CHILD SIT UP _____ CRAWL _____ STAND _____ WALK _____

DATE OF LAST DR VISIT _________________ PURPOSE ____

IMMUNIZATION HISTORY ____

OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: IN THE PAST 6 MONTHS ________ IN HIS/HER LIFETIME ______________

ILLNESS HISTORY CHICKEN POX MUMPS MEASLES RUBELLA RUBEOLA WHOOPING COUGH OTHER ________________

CURRENT MEDICATIONS ____

OTHER PRIOR MEDICATIONS ____

VITAMINS/SUPPLEMENTS ____

PREVIOUS CHIROPRACTOR ____

DATE OF LAST VISIT ___________ PURPOSE ____

OF HOURS OF SLEEP PER NIGHT _________ QUALITY OF SLEEP? GOOD FAIR POOR

HAS YOUR CHILD EVER BEEN TREATEND ON AN EMERGENCY BASIS? Y N IF YES, WHY? ___________________________

SURGICAL HISTORY ____

FAMILY ILLNESSES? ____

____

DOES YOUR CHILD REGULARLY CONSUME:

( ) FAST FOOD	( ) SODA	( ) CAFFEINE	( ) SUGARY FOODS	( ) PROCESSED FOODS
( ) SPORTS DRINKS	( ) ARTIFICIAL SWEETENERS	( ) FRUITS	( ) VEGETABLES	( ) WATER

HOW WOULD YOU RATE THE QUALITY OF YOUR CHILDS DIET? EXCELLENT GOOD FAIR POOR

HAS YOUR CHILD EVER SUFFERED FROM:

( ) HEADACHES	( ) DIZZINESS	( ) FAINTING	( ) SEIZURES
( ) HEART PROBLEMS	( ) ASTHMA	( ) CHRONIC EAR ACHES	( ) SINUS PROBLEMS
( ) ALLERGIES	( ) COLDS/FLU	( ) COLIC	( ) STOMACHACHES
( ) ORTHOPEDIC PROBLEMS	( ) NECK PROBLEMS	( ) ARM PROBLEMS	( ) LEG PROBLEMS
( ) JOINT PAIN	( ) BACK PAIN	( ) POOR POSTURE	( ) SCOLIOSIS
( ) WALKING TROUBLE	( ) BROKEN BONES	( ) DIGESTIVE PROBLEMS	( ) REFLUX
( ) CONSTIPATION	( ) DIARRHEA	( ) DIABETES	( ) HYPERTENSION
( ) ANEMIA	( ) BED WETTING	( ) BEHAVIORAL PROBLEMS	( ) ADD/ADHD
( ) HERNIA	( ) GROWING PAINS	( ) VACCINE REACTION	( ) OTHER ______________

HAS YOUR CHILD EVER EXPERIENCED THE FOLLOWING SPINAL TRAUMAS?

( ) FALL FROM CRIB	( ) FALL FROM HIGHCHAIR	( ) FALL FROM CHANGING TABLE	( ) FALL FROM BED
( ) FALL AT PLAYGROUND	( ) FALL DOWN STAIRS	( ) FALL OFF BICYCLE	( ) DIFFICULT BIRTH
( ) SPORTS INJURIES	( ) AUTO ACCIDENT	( ) OTHER ____	

ARE THERE ANY OTHER QUESTIONS OR CONCERNS YOU HAVE (OR HAVE HAD) ABOUT YOUR CHILD'S HEALTH? ______________________

____

AUTHORIZATION FOR CHIROPRACTIC CARE OF A MINOR

I hereby authorize this office and it's doctor(s) to administer care as deemed necessary to my son/daughter ________________________(name of child). I realize that I am responsible for all fees charged by this office, whether or not covered by insurance, and that I will pay for all services as they are performed. I authorize direct payment of any and all insurance benefits to Dr. Deborah Morrone and Frederick Chiropractic Wellness Center, Inc.

PARENT/GUARDIAN NAME ____

Signature ____ *Date* __________________________

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Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most 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 artery injury that could lead to stroke.
Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or 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.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________________	______________________________
Patient Name (printed)	Relationship to patient
______________________________	______________________________
Patient or legal Guardian Signature	Date
______________________________	______________________________
Witness Signature (office staff)	Date

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Error!
NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Our practice has the right to accept or deny your request.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records, in writing. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you upon written request. Such requests will be fulfilled within 60 days.

In the future, we may contact you to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest you.

You have the right to request confidential communications by alternative means or to an alternative location (i.e., you may request that you be contacted in a specified place or manner).

Notice regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. 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. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care or on your relationship with our staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name ___________________________ Signature ____________________________ Date_____________

The effective date of this Notice of Privacy Practices is March 15, 2009

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PATIENT AUTHORIZATION

Name ____ Date ________________________

Email Address ____

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care or relationship with Frederick Chiropractic Wellness Center, Inc. By initialing below, you authorize the following:

Appointment Reminders and Scheduling Related Matters _________

This office may use your name, address, telephone number, or email for the purpose of contacting you to remind you of scheduled appointments, re-evaluations, or other health care and scheduling related matters.

Preferred method(s) of contact: Email Home phone Work phone Cell phone

Contact Regarding Chiropractic and Health Related Information __________

This office may use your name, address, telephone number, or email for the purpose of contacting you to advise you about health related meetings, workshops, and products. You will also be placed on our mailing list for our bi-monthly e-newsletter. You may unsubscribe to the newsletters anytime by going to www.frederickchiro.com.

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow up to 30 days for change in our system to be completed.

Thank you!