

Frederick Chiropractic Wellness Center

Dr. Deborah Morrone

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

www.frederickchiro.com

CHILD'S NAME _____ MOTHER'S NAME _____ DOB _____
ADDRESS _____ FATHER'S 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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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 _____

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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!