

**BULL CITY FAMILY CHIROPRACTIC  
PEDIATRIC HISTORY FORM**

**PATIENT DEMOGRAPHICS**

HR#: \_\_\_\_\_

Childs Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Mothers Name: \_\_\_\_\_ Mother's Mobile \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Fathers name: \_\_\_\_\_ Father's Mobile \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_ City & State \_\_\_\_\_

Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for visit: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

Father's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Mother's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other (please explain): \_\_\_\_\_

**CHILD'S CURRENT PROBLEM:**

**Purpose of this visit:** \_\_\_\_\_ Wellness Check-up \_\_\_\_\_ Injury or Accident \_\_\_\_\_ Other

Please explain: \_\_\_\_\_

If your child is experiencing **Pain/Discomfort please identify where and for how long** \_\_\_\_\_

1. **When did the** Problem first begin? Date \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ Unknown \_\_\_\_\_ Gradual \_\_\_\_\_ Sudden

2. **Ever had** this problem **before**? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes when? \_\_\_\_\_

3. Any **bowel or bladder** problems since this problem began?: If yes, (Describe): \_\_\_\_\_

4. Have you seen any **other doctors** for this problem? No Yes If yes who? \_\_\_\_\_

5. How long ago? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

6. What were the results of past treatment? \_\_\_\_\_

7. How is this problem **NOW**:  Rapidly Improving  Improving Slowly  About the Same  Gradually Worsening  On & Off

8. Please list any **medication taken** for this problem: \_\_\_\_\_

9. Has your child ever sustained an injury playing organized sports? \_\_\_\_\_ If yes; please explain

\_\_\_\_\_  
\_\_\_\_\_

10. Has your child ever sustained an injury in an auto accident? \_\_\_\_\_ if yes, please explain

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**HAS YOUR CHILD EVER SUFFERED FROM:** *mark a Y for YES OR N N*

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Orthopedic Problems    | <input type="checkbox"/> Digestive Disorders        | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Neck Problems          | <input type="checkbox"/> Poor Appetite              | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Arm Problems           | <input type="checkbox"/> Stomach Aches              | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions     | <input type="checkbox"/> Leg Problems           | <input type="checkbox"/> Reflux                     | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Joint Problems         | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches         | <input type="checkbox"/> Backaches              | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Walking Trouble     |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Broken Bones               | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Fall in baby walker      | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib             | <input type="checkbox"/> Fall off swing      |
| <input type="checkbox"/> Fall off bicycle         | <input type="checkbox"/> Fall from high chair   | <input type="checkbox"/> Fall off slide             | <input type="checkbox"/> Fall down stairs    |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____        |

I understand that I am directly and fully responsible to Bull City Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

\_\_\_\_\_  
Parent or Legal Guardian's Signature

\_\_\_\_\_  
Date

Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_

JDD,DC 5/2011

## BULL CITY FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

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. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean 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.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. 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.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. 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.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Rachel Sorg at (919) 973-3320. If she is unavailable, you may make an appointment to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

Patient initials: \_\_\_\_\_-retaining page 1 of 2

**Bull City Family Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....**

I have received a copy of Bull City Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# OUR OFFICE POLICIES

## Welcome to Bull City Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Bull City Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body’s innate wisdom. The doctors use structurally corrective chiropractic techniques to accomplish this goal, including but not limited to diversified adjustments, drop table, arthrostim, and myofascial release. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through **two** distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT’S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient’s family

understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

*Note: Patient retains the above Notice of Office Policies and Bull City Family Chiropractic retains the signature sheet.*

**Patient initials: \_\_\_\_\_-retaining pages 1 of 2**

*I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date