Pediatric Patient Information

Child's Name:_____ Female:____ Male:_____ DOB:__/__/____ Age:_____ SSN:___/__/____
Email:_____ Home Phone:_____ Cell Phone:_____ Cell Provider: _____

Preferred method of communication for reminders: □ Email □ Text □ Phone Call

Mailing Address: _____ City:_____ State:____ Zip:_____

Mother's Name:_____ Father's Name:_____ Legal Guardian: _____
Patient's Personal Physician:_____ Type of Dr._____
Who can we thank for referring you in?_____ Relationship: _____
Emergency Contact:_____ Relationship:_____

I choose to decline a receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care.)
Patient Signature:_____ Date:_____

Consent of Treatment of a minor

I hereby authorize Dr._____ and whomever he/she so designate as their assistant, to administer chiropractic care as he/she deems necessary to my son/daughter, _____, dated at San Luis Obispo this _____ day of _____, of 20_____.
Print: _____ Signature:_____ Date:_____

For Office Use Only
Witness Name:_____ Witness Signature:_____ Date:_____

Health History and Wellness

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation:
□ Vertex Breech □ Transverse □ Face/Brow

Type of Birth:
□ Vaginal □ Vaginal-Induced □ Forceps □ Cesarean
□Vacuum

Location:
□ Home □ Birthing Center □ Hospital

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Number of weeks of gestation: □ Pre-Term # weeks_____ □ Full Term
Please explain any problems experienced during pregnancy:

_____

_____

Please explain any problems experienced during labor/delivery:

_____

_____

Was there a presence at birth of:
□ Jaundice (yellow) □ Cyanosis (Blue) □ Congenital Anomalies
If yes, please explain:_____

Infant Feeding
□ Breast □ Bottle, If bottle which formula?_____
At which age was child introduced to solid foods:_____ Any negative reactions?_____
Vaccinations: □ None □ Some □ All Vaccinations up to day for age
Any reactions:_____
Estimate courses of anti-biotics during 1st year of life:_____ Total since birth: _____

At what age did child:

Milestone	Age
Sit up	
Crawl	
Walk	

Does child have unexplained rashes or itching? _____
Does child have dry skin or eczema? _____
Does child get headaches? _____

Has child (not a family member) ever been diagnosed with:

Condition	Never	Past	Yes: Please explain
ADD or ADHD			
Allergies/Hay Fever			
Asperger's Syndrome			
Anemia			
Autism			
Bladder/Urine Infection			
Blood Pressure Problems			
Bronchitis/Pneumonia			
Colitis/Crohn's Disease			
Croup			
Cystic Fibrosis			
Developmental Delay			

Condition	None	Past	Yes: Please explain
Diabetes (Juvenile)			
Dysentery/Food Poisoning			
Ear Infection			
Easy Bruising			
Eating Disorder			
Eczema/Psoriasis			
Enlarged Heart			
Epilepsy (Seizures)			
Gastric Reflux or Ulcers			
Goiter			
Heart Murmur/Arrhythmia			
Hemochromatosis			
Hepatitis/Jaundice			
Hives			
Hyperthyroidism			
Hypothyroidism			
Irritable Bowel			
Juvenile Rheumatoid Arthritis			
Kidney Infection			
Kidney Stones			
Learning Disorder			
Lyme Disease			
Meningitis			
Mental Retardation			
Migraine Headaches			
Mononucleosis			
Multiple Sclerosis			
OCD			
Pervasive Developmental Disorder			
Pharyntgitis			
Sinusitis			
Speech Delay			
Strep Throat			
Syphilis/Chlamydia/STD			
Tourette's			
Yeast Infections			

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Allergies

Allergies:
Is child sensitive/intolerant/allergic to any food?_____

Diet:

Milk/Dairy	Wheat/Gluten	Peanuts	Soy
Corn	Yeast	Chocolate	Eggs
Citrus	Fish/Shellfish	Strawberries	

How many meals plus snacks per day does child eat on average? 1 2 3 4 5 Graze

Does child eat fruits and vegetables? □ Frequently □ Rarely □ Almost never

How many times/week, on average, does child eat Fish/Seafood?
□ More than 3 □ Rarely 1-2x/week □ Almost Never

Which Fats/Oils does child consume? Circle all that apply

Butter	Olive Oil	Coconut Oil	Flax Oil	Safflower Oil
Sunflower Oil	Peanut Oil	Grape Seed Oil	Macadamia Oil	Mayonnaise
Margarine	Crisco	Corn Oil	Soybean Oil	Canola Oil

Is child on any special diet? Circle all that apply

Dairy-Free	Wheat/Gluten Free	Yeast-Free
Feingold	Low Carbohydrate	High Protein

Do you live with any pets? □ No □ Yes, if yes, how many _____

Please list any allergies that your child has been diagnosed with or that you suspect:
_____

Does anyone in the home smoke? □ Never □No □ Yes Type: □ Cigarettes □ Cigars □ Pipes

Medications/Supplements	Dosage

List any other serious medical condition child has ever had:

Medical Condition	Surgeries	Serious Accident/Trauma

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Devices: Circle any of the following that the child utilizes:

Ear Tubes	Eyeglasses	Contact Lenses	Dental Braces	Back Brace
Knee Brace	Neck Brace	Implants	Shunt	

How is child's dental health?

□Excellent □ Good □ Fair □ Poor

Has child had eye exam?

□ No □Yes, Date last eye exam_____

Has child had hearing exam?

□ No □ Yes, date last hearing exam _____

Tests: Circle any of the following tests child has had

X-ray	Cat-scan	MRI	Sonogram
PET-Scan	EKG	Bone Scan	

Main reason for and goal for appointment:

_____

_____

_____

_____

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FINANCIAL OPTIONS

SLO Wellness Center is a Patient Centered Practice. We provide care based on a patients desire to obtain optimum health. We also offer simple solutions for understanding and using your insurance benefits. Please follow the flow chart below to understand more about your specific insurance benefits.

INSURANCE	
In Network Insurance	**Out of Network Insurance**
Blue Shield PPO United Health Care PHCS Multi Plan Marian (dignity health) CCPN	*Blue Cross Aetna Cigna Health Net Medicare All HMO Plans
As a courtesy we will bill your insurance for your treatment	
Deductible: _____ Left: _____ Estimated copay/co-insurance:_____ Visits (Per Year): _____ Estimated Initial Visit: $88 -$125 Estimated Follow up Visit: $52	Deductible:_____ Left:_____ Initial Visit: $130 Follow up visits: $55 *Blue Cross SISC, PG&E or Anthem plans managed by ASHP allow 5 visits per year
*If your deductible is met, it will be your responsibility to pay your copay or co-insurance at time of service **	*If your plan has out of network benefits, any reimbursement for treatment will come directly to you**

NO INSURANCE	
Initial Visit: $75	**Follow up Visit: $35**
Please inquire about our package rates or family plans and check with your doctor to see what would be the best option for your treatment plan.	

Please note:

- **There is a $5.00 late fee for all unpaid bills over 30 days**
- **There is a $25.00 fee for missed appointments and those not cancelled 24 hours in advance**

Signature_____ Date_____

**In order to receive insurance benefits, the member must be covered at the time of service.*

The amounts above are only estimates; we will know the exact amount when we receive the explanation of benefits from your insurance. As quoted by your insurance company, this is not a guarantee of payment or coverage. This information does not pre-authorize payment. Benefits are subject to change. Other terms and limitations may apply even though such provisions are not indicated on your insurance company's web site. All claims are subject to medical review according to the information submitted by the provider of the service and are subject to benefit maximums and other terms of the member's contract. Please refer to the applicable benefit agreements to determine the appropriate payment amounts and any limitations or exclusions. If this is HMO coverage, benefits must be authorized by the member's assigned medical group.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with the opportunity to review a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of SLO Wellness Center health care operations. The Notice of Privacy Practices also describes my rights, SLO Wellness Center duties with respect to my protected health information. The Notice of Privacy Practices is posted by the front desk.

SLO Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

SLO Wellness Center may need to use my name, address, phone number, and my clinical record to contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me. If this contact is made by phone and I am not at home, a message will be left on my answering machine. By signing this form, I am giving SLO Wellness Center authorization to contact me with these reminders and information.

Patient Name:_____ Patient Signature:_____ Date:_____

If patient is under 18 years of age

Legal Guardian Name:_____ Legal Guardian Signature:_____ Date:_____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ CAREFULLY AND INITIAL EACH SECTION

SLO Wellness Center (SWC) is a partnership between Stevens Chiropractic Inc., Sachs Chiropractic Inc., and Casparian Chiropractic Inc. SWC invites you to discuss with us any questions regarding your care and our services.

____ I understand that SWC can bill my insurance as a courtesy and that I am ultimately responsible for my payment of services provided.

____ I authorize SWC and whomever they designate to administer treatment as they deem necessary.

____ I authorize my provider(s) and/or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

____ I consent to the performance of chiropractic adjustments and other chiropractic procedures by SWC D.C.'s including: Dr. Molly Stevens, Dr. Rex Stevens. Dr. Sandy Sachs, Dr. Aram Casparian.

____ I have read, or have had read to me, the above consent. By signing below I agree to chiropractic services and intend this consent form to cover the entire course of treatment for my present condition(s) and for any further condition(s) for which I seek treatment in this office.

Patient Name:_____ Patient Signature:_____ Date:_____

If patient is under 18 years of age

Legal Guardian Name:_____ Legal Guardian Signature:_____ Date:_____

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Witness Name (office staff):_____ Witness Signature:_____ Date:_____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ CAREFULLY AND SIGN BELOW

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Patient Signature:_____ Date:_____

If patient is under 18 years of age

Legal Guardian Name:_____ Legal Guardian Signature:_____ Date:_____

Witness Name (office staff):_____ Witness Signature:_____ Date:_____

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