

Whom may we thank for referring you to this office _____?

PEDIATRIC HISTORY FORM

Thrive Wellness Center | Dr. Nick Pratt, B.A., D.C. | 2766 Commerce Dr. NW | Rochester, MN Zip | (xxx) xxx-xxxx

PATIENT DEMOGRAPHICS

Child's Name: _____ Today's Date ____/____/____ HR#: _____

Date of Birth: ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone (Home): _____

Mother's Name: _____ Mother's Cell #: _____ DOB: ____/____/____

Father's Name: _____ Father's Cell #: _____ 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, explain when: _____

3. Any bowel or bladder problems since this problem began? No Yes If Yes, describe: _____

4. Have you seen any other doctors for this problem? No Yes If so, who? _____

How long ago? _____ Days _____ Weeks _____ Months _____ Years

5. What were the results of past treatment(s)? _____

6. How is this problem now: Rapidly Improving Improving Slowly About the Same Gradually Worsening

On & Off

7. Please list any medication(s) taken: _____

8. Has your child ever sustained an injury playing organized sports? No Yes

If yes, please explain: _____

9. Has your child ever sustained an injury in an auto accident? No Yes

If yes, please explain: _____

HAS YOUR CHILD EVER SUFFERED FROM: Please checkmark (✓) for YES or leave blank for NO

<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 / Hernias
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Leg Problems	<input type="checkbox"/> Reflux	<input type="checkbox"/> Seizures / Convulsions
<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
<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 crib	<input type="checkbox"/> Fall from bed or couch	<input type="checkbox"/> Fall from Changing Table
<input type="checkbox"/> Fall of bicycle	<input type="checkbox"/> Fall off slide	<input type="checkbox"/> Fall from high chair	<input type="checkbox"/> Fall off Skateboard / Skates
<input type="checkbox"/> Fall of swing	<input type="checkbox"/> Fall down stairs	<input type="checkbox"/> Fall off monkey bars	<input type="checkbox"/> Other: _____

I understand that I am directly and fully responsible to Thrive Wellness Center for all fees associated with the 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 right to select and authorize health care service 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 Thrive Wellness Center.

Parent or Legal Guardian's Signature

Date

Doctor's Signature

Date

THRIVE WELLNESS CENTER'S 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 copied in report folders labeled '**HIPPA**' on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. 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 & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming 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 mailing 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 via email, 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 Thrive Wellness Center at (507) 258-4100. If we are unavailable, you may make an appointment with our receptionist 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's initials: _____

Thrive Wellness Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

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 any 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 are kept in the reception area. At this time, I do not have any questions regarding my right or any of the information I have received.

Patient's Name

DOB

HR#

Patient's Signature

Date

Witness

Date

THRIVE WELLNESS CENTER'S INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Thrive Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature

Date

Witness' Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

The first day of my last menstrual cycle was on ____ / ____ / ____ date.

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do hereby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature

Date

Witness' Initials

THRIVE WELLNESS CENTER'S OFFICE POLICIES

Welcome to Thrive Wellness Center!

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 "Thrive Wellness Center's Office Policies," if you have any questions or 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. 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 patient 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 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 a 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 **Thrive Wellness Center** 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 specific corrective techniques to accomplish this goal, including but not limited to CLEAR INSTITUTE. 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 structural corrections to your spine that will enable your central nervous system to function optimally, thereby improving your 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 doctors' recommendations for care, will be discussed at this time, we require each new patient 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.

Thrive Wellness Center's OFFICE POLICIES continued...

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 understand 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's Signature

Date

Witness

Date