Pediatric Case History

Name:_____ File #:_____

Has your child ever recived Chiropractic Care? ❑Yes ❑No If yes, Dr._____ Year:_____

1. Birth Process - crushing or tearing injuries of the newborn's spine are prevalent in the birth process.

Yes	No			
❑	❑	Was the delivery long?Was		
❑	❑	the delivery difficult?		
❑	❑	Forceps/Caesarean/Vacuum Extraction		
		Breach/Cephalic?		
❑	❑	Home birth?		
❑	❑	Hospital birth		
❑	❑	Mother given drugs during delivery?		
❑	❑	Was labor induced?		

2. Growth and Development

Yes	No			
❑	❑	Taught how to care for spine?		
❑	❑	Did child fall out of bed?		
❑	❑	Headbanger or rocker?		
❑	❑	Breast fed?		
❑	❑	Formula?		
❑	❑	Childhood sicknesses?Accidents?		
❑	❑	Surgery?		
❑	❑	Drugs?		
❑	❑	Fell while learning to walk?		
❑	❑	Picked on by siblings?		
❑	❑	Child abuse?		
❑	❑	Spanking (how)?		
❑	❑	Pulled ear / chin?		
❑	❑	Chair pulled out when sat down?		
❑	❑	Yanked by arm?		
❑	❑	Fell down stairs?		
❑	❑	Any other traumas?		
❑	❑	Any broken bones?		

3. Dietary Habits

Fruits Vegetables Protein Sugar

Grains: Refined Unrefined

Infant Milk: Human Goat Cow: 2% / Whole Formula _____

Frequency of eating _____

Types of snacks _____

4. Temperament and Social Interaction

_____

_____

5. Symptoms and Ill Health

List your child's chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

What activities aggravate the condition / pain? _____

What activities lessen the condition / pain? _____

List other doctors consulted for this condition:

1. _____ Address _____

2. _____ Address _____

Other symptoms your child has experienced (in the past or currently):

- ❑ Headaches
- ❑ Dizziness
- ❑ Tonsillitis
- ❑ Strep throat
- ❑ Neck pain
- ❑ Ear infections
- ❑ Sinus problems
- ❑ Asthma
- ❑ Loss of memory
- ❑ Loss of balance
- ❑ Fainting
- ❑ Allergies
- ❑ Fatigue
- ❑ Sleeping problems
- ❑ Constipation
- ❑ Back pain
- ❑ Diarrhea
- ❑ Depression
- ❑ Fever
- ❑ Stomach upset

Has the child been under drug and medical care? _____ Surgery? _____

Please list with dates: _____

What medications is he/she taking? (Include antibiotics, inhalers, tylenol/aspirin, pain medications, allergy medications, etc.) _____

_____ How long? _____

What adverse side effects has the child experienced from the drugs and surgery? _____

_____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	❑	❑	❑	❑	❑
Mother's side	❑	❑	❑	❑	❑

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

Joseph A. Sheppard, D.C. _____ Date: _____

Sheppard Chiropractic, Inc.

REGISTRATION FORM

(Please Print)

Today's Date: _____/_____/_____ Primary Care Physician: _____

PATIENT INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Patient's Last Name	First	Middle	Marital Status (Circle One) Single / Married / Divorced / Separated / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	Zip Code	Social Security

Occupation	Employer	Employer Phone No.

Cell Phone No.	Home Phone No.	Please circle cell phone carrier for text remiders: Verizon / AT&T / CinciBell / Sprint / Cricket / T-Mobile / Other

E-Mail Address	Number of Children

I Found This Office Because of (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Google

❑ Friend_____ ❑ Family_____ ❑ Close to Home/Work ❑ Other _____

IN CASE OF EMERGENCY

Full Name	Relationship to Patient	Primary Phone No.	Secondary Phone No.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Sheppard Chiropractic, Inc. and whomever they may designate as their clinicians to administer care as they so deem necessary to my son/daughter/ward. I have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care

SIGNATURE: DATE:

HIPPA STATEMENT

1. By subscribing my name and signature below, I acknowledge that I have received a copy of the HIPAA guidelines and am in agreement to, and understanding with, its terms and conditions.
2. In the event that I do not answer my telephone, I hereby give permission/consent to leave relevant medical information on my answering machine or voice mail.

SIGNATURE: DATE:

PATIENT AGREEMENT

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Sheppard Chiropractic.
I understand that I am financially responsible for all services rendered and for the following, but not limited to the following reasons:
If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company (This applies to present and future visits).
Payment is required for all services at the time they are rendered including co-payments and any outstanding balances.
In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.
Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician.
I understand that I am financially responsible for any balance. I also authorize Sheppard Chiropractic or my insurance company to release any information required to process my claims.

SIGNATURE: DATE:

SHEPPARD CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** A state of optimal physical, mental and social well-being, not merely the absence of infirmity.
- **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference of the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specialized in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

By signing at the bottom of this page, **I certify that I have read and fully understand the above statements.**

Pregnancy Release:

By signing the bottom of this page, I certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period _____

Signature_____ Date_____

SHEPPARD CHIROPRACTIC

A GENERAL ANNOUNCEMENT TO ALL PATIENTS

As a "Courtesy" Sheppard Chiropractic will verify chiropractic benefits on your insurance policy. We do our best to get accurate information, however, you are ultimately responsible for any balance your insurance does not pay. **It is your responsibility to know if you have Chiropractic Benefits**.

INSURANCE CLAIMS POLICY

Our insurance department will file claims for you or your child's chiropractic treatment for payment to the insurance carrier you supplied. With electronic billing, claims are processed in **4 – 6 weeks**. We will attempt to file claims for up to 90 days following date of treatment for payment. After 90 days, you will be responsible to contact your insurance company and have them pay your benefits to us. If you choose not to do this, we will add the amount of uncollected benefit to your portion of the financial contract, and you will be responsible to pay it.

AUTO ACCIDENT CLAIM POLICY

Claims will be billed to your auto insurance under your Med Pay coverage benefits, or to your personal health insurance. If you do not have either of these types of coverage you will be required to pay at the time of each visit. If you are being represented by and attorney for this injury accident we will work with them, providing them with needed medical and billing documentation. Ohio law states that Med Pay claims will be reimbursed to the policy holder, so you accept financial responsibility for reimbursing Sheppard Chiropractic for all treatment billed to your auto Med Pay insurance.

HIPAA COMPLIANCE STATEMENT

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.

At Sheppard Chiropractic, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have concerns or would like additional information, you may contact the practice's Compliance Officer at (513) 753-7246.

Signature_____ Date_____