Confidential Pediatric Health History

Child's Name: _____ Sex: ❑ M ❑ F Date of Birth: _____ Age: _____

Mother: _____ Father: _____

Address: _____

Number City State Zip

Home or Work phone (Mom) _____ (Dad) _____

Cell phone (Mom) _____ (Dad) _____

Siblings:

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Name/Age: _____ Name/Age: _____

Email address: _____

Emergency contact name:_____ Phone number:_____

How did you find out about our office? _____

Has your child ever been under chiropractic care? ❑Yes ❑No If so, with whom? _____

Date of last adjustment? _____

Current Health

What health concern brings your child to our office?_____

_____

_____

When did the symptoms first begin? _____

How did the problem start? ❑ Suddenly ❑ Gradually ❑ Post injury ❑ Not Sure

Please explain _____

Is the condition ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

When it is worse, how does it make your child feel? _____

What effect does this problem have on your child's health? _____

_____

What effect on his/her daily activities? _____

Has your child ever had a similar condition? ❑Yes ❑No

Please explain _____

What have you done about it that has NOT worked? _____

_____

The human body is designed to be healthy. Throughout life, events occur which damage your child's ability to express optimal health. This case history will uncover the layers of damage, especially to his or her nerve system, that results in poor health. Following their exam, the doctor will outline a course of care to begin to correct these layers of damage and recover your child's innate health potential.

Pre-Birth Details

Did mom have a difficult time conceiving? ❑ Yes ❑ No (if yes, please explain including treatment) _____

_____

Any illness or health concerns with mom during conception and pregnancy? ❑ Yes ❑ No (if yes, please explain including treatment) _____

Level of mom's stress during pregnancy ❑ Low ❑ Medium ❑ High

Any complications with fetal development and when they occurred:_____

_____

List any supplements/medications/vaccinations during pregnancy and what they were for:_____

_____

_____

Was your child ever breech? ❑ Yes ❑ No ❑ Not sure

Ultrasounds during pregnancy? ❑ Yes ❑ No if yes how many? _____ Reason _____

Did mom smoke during pregnancy? ❑ Yes ❑ No

Did mom drink alcohol during pregnancy? ❑ Yes ❑ No

Pets at home? ❑ Yes ❑ No Smokers at home? ❑ Yes ❑ No

Birth Details

Child was born at _____ weeks How long was labor? _____ How long was delivery?_____

Child's birth was: ❑ At Home ❑ Birthing Center ❑ Hospital

My obstetrician/midwife/family physician was: _____

Child's birth was: ❑ Natural Vaginal (no medication/interventions)

❑ Vaginal with interventions (check all that apply)

❑ Induction ❑ Pain Medication ❑ Epidural ❑ Episiotomy

❑ Vacuum Extraction ❑ Forceps ❑ Other _____

❑ C-section → ❑ Scheduled ❑ Emergency

Please list any reasons for delivery interventions/complications:_____

_____

Did your child spend any time in the NICU ❑ Yes ❑ No If yes, how long? _____

Please explain: _____

_____

Was the child alert and responsive within 12 hours of delivery? ❑ Yes ❑ No

If no please explain:_____

Apgar score at birth: _____ Apgar score at 5 minutes: _____

Cyanosis (blue): ❑ Yes ❑ No Jaundice (yellow): ❑ Yes ❑ No If yes, light therapy used? ❑ Yes ❑ No

Child's birth weight: _____ Length: _____ Current weight: _____ Current length/height_____

Did the doctor pull or twist the baby? ❑ Yes ❑ No ❑ Not sure

Growth and Development

At what age did your child: Respond to Sound_____ Follow an Object_____ Hold up Head_____
Vocalize _____ Sit alone _____ Teethe _____ Crawl _____ Walk _____
As an infant, did your child favor one side with head tilt or rotation? ❑Yes ❑No If yes, which side?_____
Has your child had any ER visits, hospitalizations/surgeries? (please list all below including year) _____
_____
_____
According to the National Safety Council, approximately 50% of infants fall from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? ❑Yes ❑No
If so, please describe: _____

Was your child breastfed? ❑Yes ❑No If yes how long _____
Any difficulty with breastfeeding? ❑Yes ❑No If yes please explain _____
Did your child have colic? ❑Yes ❑No How long did it last? _____
Diagnosed with acid reflux? ❑Yes ❑No Treatment or medications? _____
Was formula introduced? ❑Yes ❑No At what age?_____ What type?_____
Introduction of cow's milk at age _____ Began solids at age? _____ Which solids first? _____
Please list any food/juice intolerances:_____
How would you describe your child's diet? _____
_____

Has your child had any of the following diseases?
❑Chickenpox ❑Mumps ❑Measles ❑Rubella ❑Rubeola ❑Whooping Cough
❑Other_____
Has your child received any vaccinations? ❑ Yes ❑ No How many in the last 3 months? _____Lifetime?_____
Please list which ones and any reactions: (these may include fevers, sickness, fussiness, seizures, lethargy, swelling, etc.)
_____
_____
_____

Were you told that you had a choice in vaccinating your child? ❑ Yes ❑ No
Would you like information on the other side or alternative options to vaccination? ❑ Yes ❑ No

Has your child received any antibiotics? ❑ Yes ❑ No (if yes, please list how many times, age of child and the reason)
_____
_____
Has your child received any other medications? (Including over the counter) ❑ Yes ❑ No (if yes, please list medication, reason and duration)_____
_____
_____
Please list any vitamins/herbs your child is taking _____
_____

Any difficulty bonding? ❑ Yes ❑ No If yes, please explain _____
Any behavioral problems? ❑ Yes ❑ No If yes, please explain _____
Any night tremors, sleepwalking, or difficulty sleeping? ❑ Yes ❑ No Average hours slept per night _____
If yes please explain _____
Is your child in day care? ❑ Currently ❑ Not now but in the past ❑ never
Age day care began and duration _____
Do you feel your child is developing normally for their age? ❑ Yes ❑ No explain:_____
_____

Child's Pediatrician: _____ Date of last visit:_____
Reason for visit: _____

As your child grows, they may experience many life incidents that present in events or symptoms. Please complete all of the following that applies to your child, even if already discussed above. Please mark the age of the child when the incident occurred best to your knowledge, if applicable.

As a baby/toddler, (birth to 4 years), did any of the following occur?

_____Fall from a change table	_____ Frequent crying spells	_____ Tumble down stairs
_____ Frequent fevers /colds	_____ Fall out of crib	_____ Frequent bouts of diarrhea
_____ Involved in car accident	_____ Constipation	_____ Fall off playground equipment
_____ Sleeping problems	_____ Play in a Jolly Jumper	_____ Developmental delays
_____ Frequent ear infections	_____ Colic	_____ Tonsillitis
_____ Anemia	_____Temper Tantrums	_____ Seizures
_____ Did not gain weight	_____ Sat/slept in car seat long periods	
_____ Hyperactivity/ADHD/Autism	_____ Other _____	

Please explain any of the above _____
_____
_____

As a young child, (5-12 years), did any of the following occur?

_____Fall from a tree	_____ Bed wetting	_____ Fall off a bicycle
_____ Hyperactivity/ADHD/Autism	_____ Fall off playground equipment	_____ Learning difficulties
_____ Sports accident	_____ Asthma	_____ Allergies
_____ Car accident	_____ Stomach pains	_____ Leg/knee pains
_____ Scoliosis	_____ Constipation/diarrhea	_____ Frequent fever/colds
_____ Seizures	_____ Sensory Processing Disorder	_____ Behavioral problems

_____Other_____
Please explain any of the above _____
_____
_____

As a child or adolescent, (birth-18years) has your child experienced any of the following?

_____ Headaches	_____ Numbness in arms/hands	_____ Foot/ankle/knee pains
_____ Dizziness	_____ Arm/wrist pains	_____ Tingling in arms/legs
_____ Ringing in ears	_____ Sleeping problems	_____ Neck/back pains
_____ No appetite	_____ Sinus problems	_____ Shoulder pains
_____ Hyperactivity	_____ Stomach problems	_____ Growing Pains
_____ Fatigue	_____ Weight gain/loss	_____ Other_____

Please explain any of the above _____

_____

_____

Does your child participate in any of the following activities or sports?

❑Soccer ❑Football ❑Gymnastics ❑Karate ❑Hockey ❑Basketball ❑Dance

❑Baseball ❑Softball ❑Skateboarding❑Other_____ ❑ Other_____

Do you know what a SUBLUXATION is? ❑ Yes ❑ No

Do any of your friends or relatives see a chiropractor? ❑ Yes ❑ No

If yes, do they use chiropractic for ❑ Health Maintenance & Optimization ❑Health Problems ❑Both

Are you seeking a chiropractor for ❑ Health Maintenance & Optimization ❑Health Problems ❑Both

What specifically would you like to gain from chiropractic care? _____

_____

_____

Is there anything else you feel we should know? _____

_____

_____

_____

On a scale of 1-10, how interested are you in finding out what can be done to give your child every possible health and development advantage? _____

Consent for Examination

I consent to my child receiving a chiropractic health examination today. If the doctor deems that any additional diagnostic testing may be necessary, I will be informed prior to my participation. I understand that any fee for services rendered is due today and cannot be deferred to a later date.

Signature: _____ **Date:** _____

(Patient or Guardian)

Financial Policies

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances:
  - You are covered by a State or Federal program with a mandated fee schedule i.e. Medicare
  - You are a member of our Wellness Circle Program or any other Discount Medical Plan Organization that our office participates with.
- If you do not meet any of the circumstances above, you will be required to pay the full fee at the time of service unless we have approved in advance to accept a partial payment.
- Upon verification of insurance benefits, our office will either submit insurance claims to your provider or provide you with a form for you to file for reimbursement.
- Until verification of insurance is completed, we consider your account to be on a cash basis.
- It is your responsibility to understand your insurance benefits, if any, and to provide accurate information if submission for reimbursement is desired.
- We can make NO PROMISE THAT YOUR INSURANCE COMPANY WILL PAY YOUR CLAIM.
- It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You are responsible for all charges incurred in our office.
- Missed Appointments - Failing to provide adequate notice (24 hours) of your inability to keep a regularly scheduled appointment will incur a charge equal to 50% of the scheduled service. We reserve the right to waive this fee in cases of emergency or inclement weather.
- Refunds – There are no refunds extended for services that have already been received. If you have elected to pre-pay for any part of your care, unused portions of your care MAY be eligible for a refund. The conditions for a refund will be carefully explained prior to your agreement to receive “pre-pay eligible” services. Refunds for supplements must meet the following criteria:
  - The bottle or package must be unopened.
  - The return must be within 30 days of purchase and the product must not have passed its expiration date.
  - A 15% restocking fee will be applied unless the product is being exchanged for another product at that time.
- If your account is not paid within 30 days of the date of service and no financial arrangements have been agreed upon in writing, a finance charge of 2% per month (annual percentage rate 24%) of the unpaid balance will be added monthly. Should the balance remain unpaid for 60 days after the date of service the balance will be sent to collections and the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.
- If this is a personal injury case, signing this agreement acts as a lien and all parties will be paid on services rendered.
- I hereby assign all health eligible insurance benefits to which I am entitled to I Am Wellness, 485 South 100 East Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal, e-mail or hard copy. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance status.

Signature of Responsible Party:_____ Date:_____

Informed Consent to Care

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 understand and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect own 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 hot/cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a clot with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care of 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one per one million to two million cervical adjustments.

It is also important to that you understand that 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 medications, 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 of future recommendation to receive chiropractic care and nutritional and lifestyle advice 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 care from this office.

_____ _____ _____

Signature of patient or patient representative | Date | Indicate relationship if signing for patient

_____ _____

Signature of office representative | Date

HIPPA Privacy Policies

At I Am Wellness we understand that your medical and health information is private. We know that respect for that privacy is a critical part of our relationship. We are committed to protecting the privacy of your protected health information that is in our possession. We follow strict federal and state laws that require us to maintain confidentiality of your health information. This "Notice of Privacy Practices" was created to help you understand our legal duties to protect your health information, as well as your rights in regards to your health information.

How We May Use Your Health Information

When you receive care at our office we may use your health information for treating you, billing for services rendered and conducting our normal business operations. The following are examples of how we use and disclose your health information: Treatment- We keep records of the care and services provided to you. We use these records to deliver quality care to meet your needs. We may share your health information with a specialist or representative who will assist in your treatment. Payment- We keep billing records that include payment information and documentation of services provided to you. Your information may be used to obtain payment from your insurance company or any third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that need prior notice or authorization. Health Care Operations- We use health information to continually improve the quality and effectiveness the health care services we provide. We may use your health information to train staff and students, provide customer services, and conduct required business duties.

We may also use your health information to: Recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends who are involved in your care or payment for your care and share information with third parties who assist us with treatment, payment and health care operations.

Specific Agreements (Please Circle)

Y / N - I agree to allow I Am Wellness to call my home and/or work to remind me of appointments or advise me of issues related to my care.

Y / N - I agree to allow I Am Wellness to correspond to me via email regarding my personal health matters (lab reports etc.) as well as other information regarding general health issues.

We may sharing your health information: For public health purposes such as reporting communicable diseases, work-related illness and injuries, or other diseases and injuries permitted by law; reporting deaths; and reporting reactions to drugs or problems with medical devices, to protect victims of abuse, neglect or domestic violence, for lawsuits and similar proceedings, when requested by law enforcement as required by law or court order, for Workers' Compensation or other similar programs if you are injured at work. Our office will obtain your written authorization before using or disclosing your health information other than those instances listed above (or as otherwise permitted and required by law). You may revoke your authorization at any time with a written statement.

Our Privacy Responsibilities: We are required by law to do the following: Maintain the privacy or your health information, provide this notice that describes the ways we may use and share your health information, follow the terms of the notice currently in effect.

Your Individual Rights: You may request restrictions on how we use and share your information. (However we may not be required by law to honor these requests.) You may inspect and request a copy of your health information (Fees may apply). You may make a written request for corrections or additions to your health information. You may request and additional copy of this notice. You may request an accounting of certain disclosures of your health information made by us. This would exclude an accounting of disclosures made for treatment, payment or health care operations. This excludes disclosures prior to April 14, 2007.

Contact Us

We at I Am Wellness take the matters described in this "Notice of Privacy Practices" very seriously because of our relationship with you and the legal requirements that we comply with this notice. We reserve the right to update and make changes to this notice at any time. You may request a copy of this notice from any employee at our office.

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, please feel free to contact our Privacy Coordinator:

Tammie Duggar
485 South 100 East
Bountiful UT 84010
(801) 677-7878

I have received/reviewed a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of patient or guardian Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here _____ Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____ _____

Signature of patient or patient representative | Date | Indicate relationship if signing for patient

_____ _____

Signature of office representative | Date

Rev. 4/15