

Rossi Family Chiropractic Patient History

(Please Print, All information is confidential)

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ **Social Security :** _____
Address: _____ **Birth Date :** _____
City, State, Zip: _____ **Sex** _____
Home Phone: _____ **Weight :** _____
Work Phone : _____ **Height :** _____
E-mail: _____ **Referred By :** _____

Names of Parents/Guardians : _____

Purpose for contacting us?

Other Doctors Seen for this condition: Yes No

Doctors' Names and Prior Treatments: _____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- Ear Infections Asthma/Allergies Colic Scoliosis Digestive Problems Bed Wetting
 Seizures ADHD Car Accident Chronic Colds Recurring Fevers Temper Tantrums
 Growing/Back Pains Headaches Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There? Yes No

Number of Doses of Antibiotics Your Child has Taken: _____

Within the Past Six Months: _____

Total During His/Her Lifetime: _____

List:

Vaccination History:

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Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? Yes No List: _____

Ultrasounds During Pregnancy? Yes No Number: _____

Medications During Pregnancy/Delivery? Yes No List: _____

Cigarette/Alcohol Use During Pregnancy: Yes No

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section None

Was the Intervention Emergency or Planned? Emergency Planned No intervention

Complications During Delivery? Yes No List: _____

Birth Weight: _____

Birth Length: _____

APGAR Scores: _____, _____

Feeding History:

Breast Fed? Yes No How Long: _____

Formula Fed? Yes No How Long: _____

What Type of formula? _____

Introduced to Solids at: _____ Months

Cow's Milk at: _____ Months

Food/Juice Allergies or Intolerances: Yes No

List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound? _____

Respond to visual stimuli? _____

Hold his/her head up? _____

Sit up? _____

Cross crawl? _____

Stand alone? _____ When your child could walk alone? _____

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According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? Yes No

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?

Yes No

List:

Has your child ever been involved in a car accident? Yes No

List:

Has your child been seen on an emergency basis? Yes No

List:

Other traumas not described above? Yes No

List:

Prior surgery? Yes No

List:

Menarche? Yes No Age: _____

Childhood Diseases

Chicken Pox? Yes No Age: _____

Rubella? Yes No Age: _____

Rubeola? Yes No Age: _____

Mumps? Yes No Age: _____

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Whooping cough? Yes No Age: _____
Other? Yes No Age: _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.
AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I can understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signature: _____

Witnessed: _____

Date: _____

Money Back Guarantee

We cannot guarantee your results but we want you to be satisfied that we will do everything we can to help you. If within three visits you become unhappy with your decision to consult our office, we will refund the money you paid us and make other care recommendations. After the third visit however, there will be no refunds.

I hereby certify that I understand and agree to this policy.

**ROSSI FAMILY CHIROPRACTIC
FRED ROSSI, JR., DC
1107 VALLEY RD
SUITE 4
STIRLING, NJ 07980
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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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: The state of optimal physical, mental and social well being, not merely the absence of disease or 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 to 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 diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuromusculoskeletal conditions. However, 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 another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment

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prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to 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 x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

(Signature)

(Date)">

Rossi Family Chiropractic HIPPA Compliant Form

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Rossi Family Chiropractic we may use or disclose personal and health related information about you in the following ways:

- *Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.
- *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other related information, a message

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may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- *If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preference.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaints to: Dr. Fred Rossi.

If you would like further information about our privacy policies and practices please contact: Dr. Fred Rossi.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment as described in the office's privacy notice. In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish.

If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

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If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative

Personal Representative

Date

Description of the authority to act on behalf of the patient