The Khoury Centre For Health and Wellness

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s (d.b.a. The Khoury Centre For Health And Wellness) *Notice of Privacy Practices for Protected Health Information.*

______________________________ Patient Name Printed

____________________ Date

______________________________ Patient Signature

______________________________ Witness Name Printed

____________________ Date

______________________________ Witness Signature

Confidential Parent/Child Health Questionnaire

Name of Child:________________________________ Name of Parent:________________________________

Address: ________________________________ Address (if different from parent):____________________

City: ________________________________ ________________________________

State: __________ Zip/Postal Code: ___________ State:________________ Zip: __________________

Home Phone Number: ________________________ Email Address: ________________________________

Work Phone Number: ________________________ Date of Birth:____________ Age: __________ Sex: M F

Name of Emergency Contact: ____________________ # of weeks of Pregnancy: ________________________

Phone Number of Emergency Contact: ______________ Referred To This Office By: _______________________

Name of Primary Care Physician (Pediatrician):____

PCP Address: ____

Who is Responsible For Your Child's Bill: □ You □ Spouse □ Auto Insurance □ Medicare

□ Personal Health Insurance Co.: __________________ Health Card Number: ___________________________

Insured Person's Name:________________________ Insured Person's Date of Birth: ____________________

List any concerns you have about your child's health:____

YES	NO	REGARDING PREGNANCY:
□	□	Did your diet include sugar, white flour, or trans fats?
□	□	Did you experience any back pain during pregnancy?
□	□	Did you consume any alcoholic beverages during pregnancy?
□	□	Did you smoke cigarettes, drink caffeine, or take medications?
□	□	Did you receive any vaccinations or shots?
□	□	Were you physically ill at any time?

List medications taken during pregnancy:___________________

____

YES	NO	REGARDING LABOR:
□	□	Did you experience back pain during labor?
□	□	Did you experience a difficult or prolonged labor?
□	□	Was your delivery extremely rapid?
□	□	Was your baby's presentation NOT head down?
□	□	Was your baby posterior or breech?
□	□	Was another individual supporting you during labor
□	□	and delivery?

Did the delivery involve any of the following:

YES	NO	
□	□	Forceps
□	□	Vacuum suction
□	□	C-section
□	□	Pulling or twisting of your baby
□	□	Pitocin (chemically induced labor)
□	□	Epidural

YES	NO	NUTRITION:
□	□	Did you breast feed your child? If yes, for how long?__________________
□	□	Was your baby formula-fed? If yes, what type/brand of formula? ____________
□	□	Were solid foods introduced before 6 months?

Did your baby's diet include any of the following **before 1 year old**:

YES	NO	
□	□	Cow's milk
□	□	Soy
□	□	Sugar
□	□	Trans-Fats
□	□	Wheat/Grains
□	□	White Flour
□	□	Nuts
□	□	Corn

Does your child's diet include any of the following **currently**:

YES	NO	
□	□	Cow's milk
□	□	Sugar
□	□	Artificial Sweeteners (Splenda, Nutrasweet)
□	□	Soda
□	□	White Flour
□	□	Grains or Wheat
□	□	Trans Fats (margarine, packaged foods, etc.)
□	□	Soy
□	□	Does you child have any allergies?

Where was your child delivered: □ Home □ Birthing Center □ Hospital

List any allergies (food or environmental):____

____

List your baby's first foods: ____

List your child's favorite food:____

YES	NO	**EMOTIONAL HEALTH:**
☐	☐	Does your child fail to follow directions?
☐	☐	Is your child hyperactive?
☐	☐	Does your child have difficulty socializing with others?
☐	☐	Does your child have frequent "temper tantrums?"
☐	☐	Does your child get frustrated easily?

YES	NO	**MEDICAL HISTORY:**
☐	☐	Has your child ever taken an antibiotic? Number of antibiotic prescriptions:_______________ Reason for antibiotics:_________________________ ____
☐	☐	Did your child receive any vaccinations?
☐	☐	If yes, did your child experience any behavioral or physical changes after vaccination? Describe reactions:___________________________ ____
☐	☐	Has your child ever been hospitalized? Reason and date of hospitalization:_______________ ____
☐	☐	Has your child had any surgeries? List surgeries:________________________________

YES	NO	**FAMILY HISTORY:**
☐	☐	Do any other family members have health problems? List siblings: Brother(s): Age(s) _________________________ Sister(s): Age(s) ___________________________

GROWTH AND DEVELOPMENT:

At what age did your child sit up? ______ months
At what age did your child crawl? _______months
At what age did your child walk? _______months
At what age did your child talk? _______months

Child's Height and Weight **at Birth**:
Height: ______________ Weight: ______________

Child's Height and Weight **at Last Physical**:
Height: ______________ Weight: ______________

List any concerns about your child's growth and development:
____
____

List your child's current medications and/or supplementation/vitamins:_______________________________
____
____
____
____

YES	NO	**PHYSICAL TRAUMA :**
☐	☐	Did your child ever fall when learning to sit-up, stand, walk, run, ride a bike, play sports?
☐	☐	Has your child ever fallen down, tripped, or hit his/her head?
☐	☐	Has your child ever fallen from a height greater than 2ft?
☐	☐	Has your child ever broken a bone, dislocated or sprained a joint?
☐	☐	Has your child ever been in a motor vehicle accident? Date of accident: _____________________
☐	☐	Does your child carry a backpack greater than 15% of his/her body weight?
☐	☐	Does your child spend more than 1 hour per day in front of the TV, video games, or computer?

List sports that your child is involved in:
____
____

YES	NO	**HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING HEALTH PROBLEMS?**
☐	☐	Hyperactivity/ADD
☐	☐	Ear Infections
☐	☐	Difficulty Sleeping
☐	☐	Bed Wetting
☐	☐	Irritability
☐	☐	Colic
☐	☐	Frequent Colds
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Gas Pains
☐	☐	Rashes/Eczema
☐	☐	Milk/Lactose Intolerance
☐	☐	Food sensitivities
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Headaches
☐	☐	Learning Disorder
☐	☐	Poor Posture
☐	☐	Chicken Pox
☐	☐	Pneumonia
☐	☐	Whooping Cough (Pertussis)
☐	☐	Measles
☐	☐	Flu
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Other ______________________________

THE KHOURY CENTRE POLICIES:

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

It is our policy that payments for all services are due at the time they are rendered and are not billed periodically to patients. Billing for patients' personal balances increases offices expenses resulting in higher costs of services. We accept cash, personal checks, and most credit cards.

As a courtesy to you we will bill your insurance company for their portion of the bill. All patients are expected to supply this office, in a timely manner, with any and all information necessary to file and bill your claims. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

It is understood and agreed that the amount paid to the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Although unlikely, some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my child's condition, as he or she deems appropriate.

Parent/Guardian's signature: ______________________________________ Date ________________

CONSENT TO TREATMENT OF MINOR (CHILD UNDER 18)

I hereby request and authorize the doctor(s) of The Khoury Centre to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child, the said patient.

This authorization also extends to all other doctors and trained office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date:___________________

Signature: _____________________________

Printed Name:___________________________

Relationship to Patient:____________________

Witness: ________________