STUDER
CHIROPRACTIC P.C.

It is our pleasure to be of service to you. To help us serve you better please fill out our confidential Patient Health Record completely and accurately.

Studer Chiropractic is dedicated to removing nerve interference by hand to restore and maintain optimum health.

Through education we promote a lifetime of health, strength, and vitality.

We envision chiropractic care for every man, woman and child to build a healthier community and world.

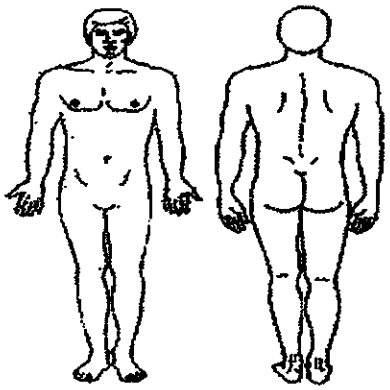
CHILD HISTORY (Ages 5-17)

ABOUT THE PATIENT

Name_____ Birth Date _____
Name of Parents/Guardians _____
Sibling's names and ages _____
Address_____City_____State____Zip_____
Phone: Home _____ Cell _____ Work _____
E-mail address _____
Would you like us to email you our free newsletter? Yes No

REASON FOR THIS VISIT

Describe the purpose of this visit _____
_____
When and how did this health challenge begin?_____
_____
Since the problem began, is it:
Getting Better Getting Worse About the Same
Using the diagram to the right please indicate with an X where you or your child notices discomfort or problems occurring. ⟶
What is the pattern of this problem?
Constant Intermittent Occasional Cyclic
What have you tried to improve this condition?
_____
Have you seen other professionals for this condition? Yes No
Dr.'s Name (s) _____
Type of Treatment _____
What are your objectives in consulting us? _____



HEALTH HISTORY

Who referred you to this office?_____
Have you been adjusted by a Chiropractor before? Yes No
Previous Chiropractor's Name _____
Date of Last Visit _____Reason for those visits?_____
Name of Pediatrician: _____ Frequency of Visits:_____
Date of last visit: _____Reason:_____
Number of doses of Antibiotics your child has taken:
During past six months_____ Total during lifetime_____
Number of doses of other prescription medications your child has taken:
During past six months_____ Total during lifetime:_____
Please list_____
Please list any OTC drugs taken in past six months_____
Has your child ever been hospitalized, had any surgeries or major illnesses?
No Yes, please explain _____
Vaccination History _____ Any reactions?_____
Have you withheld any Vaccines? No Yes Why?_____

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of **vertebral subluxations**. Subluxations may be caused by physical, chemical or emotional stress. The practice of chiropractic is based on locating and reducing nerve system interference caused by the **vertebral subluxations**.

Please check any of the following conditions that you have now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.

Colic	Seizures	Scoliosis	Recurring Fevers
Ear Infections	Bed Wetting	Headaches	Digestive Problems
Chronic Colds	Hyperactivity	Back Pain	Acid Reflux
Asthma	Temper Tantrums	Growing Pains	Poor Nutrition
Allergies	Sleeping Problems	Car Accident	Limited Exercise
Sinus Problems	Anxiety/ADHD	Dizziness	Low Energy

Other Health Conditions:_____

Does anyone in your household:	No	Yes (please explain)
Smoke?		___ # packs/day
Drink alcohol?		___ # drinks/month
Drink coffee/soda?		___ # cups/day
Exercise regularly?		_____
Take any supplements?		_____

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions.

Prenatal history:

Complications during pregnancy? No Yes, please explain_____

_____

Labor chemically induced? No Yes, why?_____

Complications during delivery? No Yes, please explain_____

_____

Birth Interventions? Forceps, Vacuum Extraction,
Cesarian Section: Emergency, Planned

Feeding History

Any difficulties eating or nursing? No Yes

Breast Fed No Yes, How long?_____

Formula Fed No Yes, Type? How long?_____

Food Allergies or Intolerances_____

Traumas

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 you? No Yes, Please Explain _____

Have you previously or are you currently involved in any sports?

No Yes, Please list the sport and length of participation _____

_____

_____

What are your hobbies? _____

Have you ever had any broken bones or sprained any joints?

No Yes, Please Explain_____

Have you ever been involved in a car accident?

No Yes, Please Explain_____

Have you been hospitalized or had any surgeries?

No Yes, Please Explain _____

Please explain any other traumas or injuries not mentioned above _____

_____

WHICH BEST DESCRIBES YOUR REASON FOR CONSULTING OUR OFFICE?

Please check the one choice that most closely describes your current goals for your child's health and wellbeing.

I am only concerned about relief of a particular symptom.

I am only concerned about relief of a particular symptom, and preventing its return.

I want optimum health and wellbeing on every level available to me.

We are here to serve you. You are encouraged to ask questions. Your participation in care is vital and will help determine your results.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Studer Chiropractic P.C. and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office and that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Parent/Guardian Signature: _____ Date: _____

STUDER
CHIROPRACTIC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records for a fee at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Guardian Signature Date

STUDER CHIROPRACTIC, P.C.
113 LOCUST STREET
MONTICELLO, MN 55362
763-295-4797 FAX 763-295-2302

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**