PEDIATRIC PATIENT HISTORY

Child's Name:_____ **SS#:**_____
Last First MI

DOB: _____ **Grade In School:** _____ **Sex:**_____ **Home Phone: (**____**)**_____

Address:_____ **City/Town:**_____ **State:**_____ **Zip:** _____

Parent/Guardian:_____ **Cell/Work Phone:** _____/_____
Last First

Parent/Guardian:_____ **Cell/Work Phone:** _____/_____
Last First

Email :_____

Referred By:_____

Purpose of this appointment:_____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

Severe viral infection during the first trimester
Breech position during pregnancy
Accident or Infections
Smoking
Severe stress
Pre-eclampsia
Alcohol consumption and/or drug use
Radiation exposure
Hypertension (high blood pressure)
Toxoplasmosis
Uncontrolled Diabetes
Toxemia

Labor and Delivery History
Did you and/or the child experience any of the following during the labor/delivery:

Hospital birth
Birthing home
Long and/or difficult labor
Placenta previa
Forceps or suction cup used
Fetal distress
Elective c-section
The child was a "blue baby"
Home birth
The labor was induced
The delivery was rapid
Breech birth
Cord around the neck
Emergency c-section
The child was premature (2+ weeks)

Comments:_____

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Newborn History
Did the child experience any of the following as a newborn:

Required resuscitation/oxygen
Prolonged jaundice
Poor sleeper
Immunizations in hospital
If yes, specify vaccine:

Distorted skull
Difficulty latching/sucking
Formula fed
Breast fed
Bottle fed
Colic

Weight at birth:_____ Length at birth:_____

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

Illnesses accompanied by a high fever
Frequent headaches
Seizures/Convulsions
Chronic ear infections/earaches
Head injury
Serious fall(s) or repetitive falls
Serious illness
Epilepsy
Meningitis
Allergies to foods
Environmental allergies
Chemical insensitivities
Undergone any surgeries
Neck or back problems
Adverse reaction to any vaccinations (even if mild)
If yes, please explain:

Dizziness
Diabetes
Hypoglycemia (low blood sugar)
Trouble with bladder control (enuresis)
Fainting
High blood pressure
Heart disease
Asthma
Sinus problems
Constipation
Diarrhea
Digestive disorders
Rheumatic Fever
Joint or muscle problems

Other:_____

Developmental History
Does or did your child have any of the following:

Difficulty with crawling (on all fours)
Difficulty learning to ride a bike
Difficulty learning to read
Difficulty using utensils
Difficulty tying shoes
Poor hand-eye coordination

Did not crawl on all fours
Appears clumsy
Difficulty with writing
Difficulty buttoning clothing
Difficulty or awkward with walking/running
Difficulty sitting still or paying attention

At what age did your child start to walk unassisted? _____

PEDIATRIC PATIENT HISTORY

Comments:_____

_____

_____

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

Hearing loss or impairment
Neurological disorders
Obsessive Compulsive Disorder (OCD)
ADD/ADHD
Dyslexia
Visual impairment
Anxiety/Depression
Autism/Autism Spectrum Disorder
Tourette's Syndrome
Other_____

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency

_____

_____

List any special dietary needs that your child has:

_____

_____

_____

List any supplements that your child takes:

_____

_____

_____

List any treatment that your child is currently undergoing with any health professional:

_____

_____

List any special services that your child is currently receiving at school or privately:

_____

_____

_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

_____

_____

Comments:_____

_____

_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Adam Glassman, D.C., C.A.C.C.P. to evaluate and treat my son/daughter as he deems necessary. I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this office.

_____ _____

Signature and relation of person completing this form **Date**

_____

Print Name of Signature

D·R·E·A·M wellness

38 Great Neck Road
Great Neck, N.Y. 11021
(516) 829-8099 (o)
(516) 829-8578 (f)
www.dreamwellness.com

Notice of Privacy for:
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that Chiropractic services have been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign in logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer, who is *Adam Glassman, D.C.*, and can be reached at *516 829-8099* regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have read and reviewed this notice with full understanding.

_____
Patient Name (Print)

_____ _____
Signature of Patient/Legal Representative Date

D·R·E·A·M wellness

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TREATMENT

Patient Signature / Date_____ Doctor's Signature:_____

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Signature of Parent/Representativen for Patient: _____