

Goulet Family Chiropractic

Pediatric

Confidential Patient History

Child's Name: _____ Parent / Guardian: _____

Address: _____ City/State/Zip: _____

Phone: (_____) _____ Email: _____

Child's Birthdate: ___/___/___ Age: _____ Height: _____ Weight: _____

Current Health Conditions

Is your child receiving care from any other health professionals? Yes _____ No _____

If yes, please name them and their specialty: _____

Please list any medications, vitamins, herbs or supplements that your child is taking: _____

What health condition(s) bring your child to be evaluated by a chiropractor? _____

When did the condition first begin? _____

How did the problem start? Suddenly _____ Gradually _____ Post Injury _____

Has your child received care for this condition before? Yes _____ No _____

If yes, please explain: _____

Is this condition Getting Worse _____ Improving _____ Intermittent _____ Constant _____ Unsure _____

What makes it worse? _____ What makes it better? _____

Pregnancy, Labor and Delivery History

Were there any medical complications during pregnancy? _____

Were there any notable episodes of mental or physical stress during pregnancy? _____

Child's birth was: Vaginal Birth _____ Scheduled C-section _____ Emergency C-section _____

Was the birth at a: Hospital _____ Birthing Center _____ Home _____ Other _____

Please check any interventions or complications. Breech _____ Induction _____ Pain meds _____

Epidural _____ Episiotomy _____ Vacuum Extraction _____ Forceps _____

Child's Birth Weigh _____ lbs _____ oz Length _____ inches

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Growth and Development History

Is / was your child breastfed? _____ If yes, how long? _____ Any difficulties with nursing? _____

Did they ever use formula? _____ If yes, what age? _____ What type: _____

Did / does your child ever suffer from colic, reflux or constipation as an infant? _____

Did / does your child frequently arch their neck / back, feel stiff or bang their head? _____

At what age did your child: Respond to sound _____ Follow an object _____ Hold head up _____

Vocalize _____ Teethe _____ Sit Alone _____ Crawl _____ Walk _____

Began cow's milk _____ Began solid food _____

Please list any food intolerance or allergies and when they began: _____

Please list any hospitalizations or surgeries and the dates performed: _____

Please list any major injuries, accidents, falls and / or fractures your child has sustained in his / her lifetime including the year: _____

Has your child received any antibiotics? Yes _____ No _____

If yes, how many times and for what reason: _____

How many hours a day does your child spend watching TV, computer, tablet, phone? _____

Any difficulty sleeping? _____

How would you describe your child's diet? _____

Parent or Guardian Signature: _____ Date: _____

**Goulet Family Chiropractic
Terms of Acceptance**

When a patient seeks chiropractic care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal – to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understands both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A 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 vertebrae 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 to diagnosis or treat any disease or condition other than vertebral subluxation. However, if during the course of 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 a healthcare provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment 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.

Consent to Evaluate and Adjust a Minor Child

I, _____, being a 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.

Signature

Date

GOULET FAMILY CHIROPRACTIC

<i>Pediatric Fee Schedule -</i>	Initial Exam/Consultation	\$40.00 - \$100.00
	Cervical X-Rays (3 views)	\$50.00
	Thoracic X-Rays (2 views)	\$50.00
	Lumbar X-Rays (2 views)	\$50.00
	Regular Adjustment	\$45.00
	Active Military Adjustment	\$25.00

Patients Without Insurance - It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. We accept cash, your personal check, MasterCard and Visa cards.

Group Or Individual Insurance - Benefits quoted to us by your insurance company are not a guarantee of payment. At time of service, you are responsible for any non-covered services, deductibles or co-pays. We will file your claim and wait payment for 90 days. You will be responsible for any charges not paid by your insurance company. Please inform us of any secondary insurance you might have.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I understand and accept the fee schedule listed above. I authorize payment of medical benefits to Dr. Jeremy M. Goulet for services provided.

Signature

Date

Goulet Family 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 these records. Before we began any healthcare 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 **PHI**, 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 **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 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 with 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 have 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 know 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 healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (**PHI**) will be used and I agree to these policies and procedures.

Print Patient Name

Patient / Guardian Signature

Date

Please Complete Back Side