PURE ALIGNMENT
CHIROPRACTIC

APPLICATION FOR CARE AT PURE ALIGNMENT CHIROPRACTIC – PEDS < 10 yo

PRACTICE MEMBER HEALTH REVIEW: Today's Date: ___ / ___ / ____ PMID#: _____

Child's Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Current Height: _____ Current Weight: _____

Parents / Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier: _____

E-mail Address: _____ Preferred Method of Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

Guardian's Driver's License Number: _____

Name & Number of Emergency Contact: _____Relationship: _____

Previous Chiropractic Care: ☐ No ☐ Yes When: _____ Where: _____

Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT:

Reason for pursuing care: ☐ Wellness ☐ Health Concern(s): _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ On and off during the day **OR** ☐ Comes and goes throughout the week

Has your child suffered from this before? ☐ No ☐ Yes

If yes, how many times? _____ When was the last episode? _____

What relieves the symptoms? _____

What makes the symptoms worse? _____

Have you tried other treatments: ☐ No ☐ Yes

If yes, please state **what** type of treatment: _____

Who provided it: _____

How long ago? _____

Were the results ☐ Favorable ☐ Unfavorable → please explain.

_____

PAST HISTORY:

If your child has ever been diagnosed or experienced any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had

___ Ear Infections ___ Scoliosis ___ Chronic Colds ___ Headaches ___ Allergies

___ Digestive Issues ___ ADHD / ADD ___ Recurring Fevers ___ Colic ___ Reflux

___ Bed Wetting ___ Temper Tantrums ___ Seizures ___ Asthma ___ Car Accident (when) _____

Other 1: _____ Other 2: _____

Is your child currently taking any medications (prescription or non-prescription)? ☐ No ☐ Yes

If yes, please list:_____

Vaccinated: ☐ No ☐ Yes

Pediatrician / Group name: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
DISEASES	→		

PRENTAL, BIRTH, INFANCY, AND DEVELOPMENT HISTORY

*If your child is **above the age of 5,** skip to LIFESTYLE*

Complications during pregnancy? ☐ No ☐ Yes **If yes,** explain: _____

Complications during labor/birth? ☐ No ☐ Yes **If yes,** explain: _____

Location of birth? ☐ Hospital ☐ Birth Center ☐ Home

Birth interventions? ☐ None ☐ Induction ☐ Forceps ☐ Vacuum Extraction ☐ Cesarean Section

For how many months was your child breastfed? _____ Formula Fed? _____

Does your child have any difficulties eating? ☐ No ☐ Yes **If yes,** please explain: _____

At what age did your child sit-up? _____ Crawl? _____ Walk? _____

Do you have any concerns about your child's growth and development? ☐ No ☐ Yes

If yes, please explain: _____

LIFESTYLE

Do you have any concerns about your child's diet? ☐ No ☐ Yes **If yes,** please explain _____

Does your child excrete stools each day? ☐ No ☐ Yes

Does your child have any digestive disturbances ☐ No ☐ Yes **If yes,** please explain: _____

Does your child have any persistent or intermittent skin rashes? ☐ No ☐ Yes **If yes,** please explain: _____

Vitamins, Supplements or probiotics? ☐ No ☐ Yes **If yes,** please list: _____

Has your child ever complained of neck, back pain, or headaches ☐ No ☐ Yes

If yes, please explain: _____

Reviewed by Dr. Katherine Burtis, D.C.

Has your child experienced **any** major falls, traumas, or injuries (fallen from height, bicycle, skateboard, scooter, etc)? ☐ No ☐ Yes

If yes, please explain: _____

I hereby authorize payment to be made directly to Pure Alignment Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Pure Alignment Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Practice Member or Authorized Person's Signature **Date**

FAMILY HISTORY:

Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes, whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ sibling(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

Does anyone in the home smoke? ☐ No ☐ Yes

Confidential Member Information – Family Health History

This form is to assist the doctor by providing past health history information for their review

****PLEASE CHECK THE APPROPRIATE BOXES BELOW****

Health Concern	Presenting Child	Sibling(s)	Mother	Father
ARM PAIN				
AUTISM				
ADD / ADHD				
ASTHMA				
ALLERGIES				
BACK PAIN				
BED WETTING				
BROKEN BONE / FRACTURE				
CANCER				
CHRONIC COLDS				
COLIC				
DIGESTIVE ISSUES				
DEVELOPMENTAL DELAY				
EAR INFECTIONS				
EXCESSIVE CRYING				
GAS				
HEADACHES				
HIP PAIN				
LEG PAIN				
MIGRAINES				
MENSTRUAL DISORDER				
NECK PAIN				
RECURRING FEVER				
RESPIRATORY PROBLEMS				
SCOLIOSIS				
SEIZURES				
SINUS TROUBLE				
SLEEPING TROUBLE				
TEMPER TANTRUMS				
OTHER (Please explain)				

Reviewed by Dr. Katherine Burtis, D.C.

INFORMED CONSENT

REGARDING Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

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 vertebrae 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 practice members 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.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Pure Alignment Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Pure Alignment Chiropractic by any means, method, and or techniques, the doctor deems necessary at any time throughout the entire clinical course of my care.

Witness Initials

_____ ____/____/____

Practice Member or Authorized Person's Signature Date

Reviewed by Dr. Katherine Burtis, D.C.

REGARDING Parental Consent for Minor Practice Member

Practice Member Name: _____ Practice Member Age: _____ DOB: _____

Printed name of person legally authorized to sign for: _____

Signature: _____

Relationship to Practice Member: _____

In addition, by signing below, I give permission for the above named minor practice member to be managed by the doctor even when I am not present to observe such care. The following adults are allowed to bring my child for their visit and supervise their care:

Printed name of person legally authorized to sign for

Name: _____ Relationship to Practice Member: _____

Name: _____ Relationship to Practice Member: _____

PURE ALIGNMENT CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.** (Please note: x-rays are utilized in this office to locate and analyze vertebral

subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are noted, we will bring it to your attention so you can seek proper medical advice.

COMPLAINTS

If you wish to make a formal compliant about how we handle your health information, please call Dr. Katherine Burtis at (386)-473-5926. If she is unavailable, you may make an appointment with our front desk coordinator to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you may submit a formal complain to:

DHHS, Office of Civil Rights
200 Independence Ave. SW Room
509F HHH Building
Washington DC 20201

I have received a copy of PURE ALIGNMENT CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____
Parent/Guardian's Name

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness Date