TURNING POINT CHIROPRACTIC

# PEDIATRIC HISTORY FORM

Today's Date: _____ HR#: _____

## PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Mother's Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

Who is responsible for this bill? _____

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: _____ ○ Mother's Driver's License #: _____

○ Other *(please explain)*: _____

## CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:

_____

_____

TURNING POINT CHIROPRACTIC

10. Has your child ever sustained an injury in an auto accident? ○ No ○ Yes **If yes,** please explain:

_____

_____

**HAS YOUR CHILD EVER SUFFERED FROM** - *Check all that apply*

| | | | |
|---|---|---|---|
| ○ Headaches | ○ Orthopedic Problems | ○ Digestive Disorders | ○ Behavioral Problems |
| ○ Dizziness | ○ Neck Problems | ○ Poor Appetite | ○ ADD/ADHD |
| ○ Fainting | ○ Arm Problems | ○ Stomach Aches | ○ Ruptures/Hernia |
| ○ Seizures/Convulsions | ○ Leg Problems | ○ Reflux | ○ Muscle Pain |
| ○ Heart Trouble | ○ Joint Problems | ○ Constipation | ○ Growing Pains |
| ○ Chronic Earaches | ○ Backaches | ○ Diarrhea | ○ Asthma |
| ○ Sinus Trouble | ○ Poor Posture | ○ Hypertension | ○ Walking Trouble |
| ○ Scoliosis | ○ Anemia | ○ Colds/Flu | ○ Sleeping Problems |
| ○ Bed Wetting | ○ Colic | ○ Broken Bones | ○ Fall off swing |
| ○ Fall in baby walker | ○ Fall from bed or couch | ○ Fall from crib | ○ Fall down stairs |
| ○ Fall off bicycle | ○ Fall from high chair | ○ Fall off slide | |
| ○ Fall from changing table | ○ Fall off monkey bars | ○ Fall off skateboard/skates | |

○ Allergies to _____

○ Other: _____

I understand that I am directly and fully responsible to [Insert Practice Name] for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

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

_____ _____ - _____ - _____

**Parent or Legal Guardian's Signature** **Date Completed**

_____ _____ - _____ - _____

**Doctor's Signature** **Date Form Reviewed**

TURNING POINT CHIROPRACTIC

# Pediatric Examination Form (Doctor use only)

**Number:** _____

**PATIENT NAME:** _____ **DATE:** _____

**Vitals:** Length: _____ Weight: _____ HR: _____ Temperature: _____ Age: _____

**KINESIOPATHOLOGY**

CERVICAL ROM WNL ☐

C EXT_____

C FLEX_____

C RROT_____

C LROT_____

C RLF_____

C LLF_____

THORACIC/LUMBAR ROM WNL ☐

TL EXT_____

TL FLEX_____

TL RROT_____

TL LROT_____

TL RLF_____

TL LLF_____

**MYOPATHOLOGY**

Spasm: _____

_____

**MOVEMENT OF ARMS AND LEGS**

SYMMETRICAL: Y/N _____

TONE: GOOD / ELEVATED / DIMINISHED _____

**NEUROPATHOPHYSIOLOGY**

**Cranial Nerves: N** L/R or I,II,III,IV,V,VI,VII,VIII,IX,X,XI,XII

**FONTANELS**: ANT: P/A POST: P/A

**SHAPE OF CRANIUM**: WNL ☐

_____

_____

_____

**Facial Observation:** WNL ☐

_____

_____

**SLR: N** L+/R+ **Knee Chest: N** L+/R+

**Heel Buttocks: N** L+/R+ **Fig4 N** L+/R+

**POSTURE FOR LEGS**

**HIPS: N** Asymmetrical/Rotated

**Ortolini: N** L+/R+ **Barlow: N** L+/R+ for click

**KNEES: N** Varus / Valgus L/R

**FEET & ANKLES**: **N** pronated / supine

**Calcaneous: N** valgus / varus L/R

**Talipes equinovarus**: **N** L/R rigid / functional

**POSTURAL EVALUATION:**

_____

_____

_____

| L | SPH | R |
|---|---|---|
| | C0 | |
| | C1 | |
| | C2 | |
| | C3 | |
| | C4 | |
| | C5 | |
| | C6 | |
| | C7 | |
| | T1 | |
| | T2 | |
| | T3 | |
| | T4 | |
| | T5 | |
| | T6 | |
| | T7 | |
| | T8 | |
| | T9 | |
| | T10 | |
| | T11 | |
| | T12 | |
| | L1 | |
| | L2 | |
| | L3 | |
| | L4 | |
| | L5 | |
| | SAC | |
| | SI | |
| | CX | |

**REFLEXES**

| | | |
|---|---|---|
| Bicep | N | L/R |
| Brachial | N | L/R |
| Tricep | N | L/R |
| Patella | N | L/R |
| Achilles | N | L/R |
| Babinski | N | L/R |
| Abdomen | N | L/R |

KEY

N = Normal
P = Present
A= Absent
Y/N = Yes/No
L/R = Left/Right
SAC = Sacrum
SI = Sacroiliac Joint
CX = Coccyx
SPH = Sphenoid
WNL = Within Normal Limits

TURNING POINT CHIROPRACTIC

Accommodation: Direct / Indire

**HISTOPATHOLOGY**

+ JUMP SIGN: _____ Lymph Nodes: **N** _____

Inflammation_____ Tissue congestion Y/N_____

Bogginess/Dark circles under eyes: Y/N_____

Bruising Y/N _____

**SPECIAL TESTS**

Head circumference full: _____ Chest circumference_____

Nasopalpation (blink) P/A Palmer Grasp: P/A Plantar grasp: P/A

Rooting: P/A Sucking: P/A Gag: P/A Moro: P/A Inversion: N /_____

Rotation: P/A Placing: P/A Steppage: P/A Fencer: P/A Galant: P/A

Leg Check: D+ / D- L/R Cervical Syndrome: Y/N Bilateral - R/L

Glut Squeeze: N L/R Stair Step: N or Absent High Occiput: Y/N L/R

**EXTREMITIES:**_____
_____
_____

## GENERAL OVERVIEW

***KINESIOPATHOLOGY:*** *mild, mod, severe, extreme*
***MYOPATHOLOGY:*** *mild, mod, severe, extreme*
***HISTOPATHOLOGY:*** *mild, mod, severe, extreme*
***NEUROPATHOPHYSIOLOGY:*** *mild, mod, severe, extreme*

***COMPLICATING FACTORS: STRESS ____ REPETATIVE POSTURES ___***
***DECONDITIONED ____ POOR DIET____ TRAUMA ____ ANOMALY____***

**CASE SUMMARY** _____
_____

TURNING POINT CHIROPRACTIC

# Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Turning Point Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____ ☐ *Witness Initials*
Patient or Authorized Person's Signature Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY:** *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

TURNING POINT CHIROPRACTIC

_____

Patient Name (print)

_____ ___/___/___ *Witness Initials*

Patient or Authorized Person's Signature Date

TURNING POINT CHIROPRACTIC

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

---

AUTHORIZATION

I, _____authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____

---

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

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TURNING POINT CHIROPRACTIC

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____ Parent's Name:

_____

Daytime Phone: _____ Daytime Phone:

_____

Evening Phone: _____ Evening Phone:

_____

Cell Phone: _____ Cell Phone:

_____

_____ _____

Signature of Parent or Legal Guardian Date

# Turning Point 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. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**
If you wish to make a formal complaint about how we handle your health information, please call Dr. Arnold Koo at (925) 396-8004 If she/he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

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

*Patient initials:* **_____-retaining *page 1 of 2***

***Turning Point Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…***

I have received a copy of Turning Point 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.

| Patient's Name | DOB | HR# |
|---|---|---|

| Patient's Signature | Date |
|---|---|

| Witness | Date |
|---|---|