ABUNDANCE
CHIROPRACTIC

PEDIATRIC HEALTH PROFILE

INFORMATION

Last Name_____ **First Name**_____ **Date of Birth**____/____/_____

Gender: □Male □Female **Birth: Height**_____ **Weight**_____ **Current Height**:_____

Address_____**City**_____**State**_____**Zip**_____

Mothers Name:_____ **Mothers DOB** _____**SS#**_____

Cell Phone_____ **Email** _____

Fathers Name:_____ **Fathers DOB** _____**SS#**_____

Cell Phone_____ **Email** _____

Guardian Name:_____ **Guardian DOB** _____**SS#**_____

Cell Phone_____ **Email** _____

Pediatrician/Family MD_____ **City/State**_____

Who is Responsible for this bill? _____

INTAKE

Purpose of this visit? □ Wellness □injury or accident □Other

If your child is experiencing any pain or discomfort please identify where and for how long:

_____

_____

When did the problem first begin? _____ □Unknown □Gradual □Sudden

Has ever occurred before? □Yes □No If yes, when?_____

Have you seen any other doctors for this problem? □ No □ Yes If yes, who _____

What were the results of the past treatment? _____

Describe the problem now: □ Rapidly Improving □Improving Slowly □Same □Gradually worsening

Please list any medication taken for this problem: _____

Have there been any bowel or bladder problems since this problem began? □ No □ Yes

If yes, describe _____ Date_____

Quality of sleep: □Poor □Fair □Average □Good □Excellent

Do you have any emotional or behavioral issues: □No □Yes: _____

SYMPTOMS

CHECK ALL THAT APPLY

- ❑ Neck issues
- ❑ Headaches
- ❑ Migraines
- ❑ Fainting
- ❑ Dizziness
- ❑ Sinus Trouble
- ❑ Colds/ Flu
- ❑ Ear Infections
- ❑ Chronic Ear Aches
- ❑ Seizures/ Convulsions
- ❑ ADD/ ADHD
- ❑ Heart Trouble
- ❑ Hypertension
- ❑ Anemia
- ❑ Ruptures/Hernia
- ❑ Chronic Fatigue
- ❑ Muscle pain
- ❑ Growing pains
- ❑ Orthopedic issues
- ❑ Arm problems
- ❑ Leg problems
- ❑ Joint problems
- ❑ Walking trouble
- ❑ Back Aches
- ❑ Poor posture
- ❑ Scoliosis
- ❑ Reflux
- ❑ Poor appetite
- ❑ Digestive Disorders
- ❑ Constipation
- ❑ Diarrhea
- ❑ Stomach Aches
- ❑ Bed Wetting
- ❑ Sleeping problems
- ❑ Asthma
- ❑ Allergies _____

PREVIOUS HISTORY Has the Child experienced any of the following in the past

CHECK ALL THAT APPLY

- ❑ Bed wetting
- ❑ Colic
- ❑ Broken Bones
- ❑ Seizures
- ❑ Fall from Crib
- ❑ Fall off swing
- ❑ Fall down stairs
- ❑ Fall from changing table
- ❑ Fall off monkey bars
- ❑ Fall off Skateboard/skates
- ❑ Fall in baby walker
- ❑ Fall from bed or couch
- ❑ Fall from high chair
- ❑ Fall from crib
- ❑ Other _____

Notes (CA only):

HEALTH HISTORY

List Current Medications_____

_____

List all Surgical Operations and Dates_____

_____

Has the child ever been in an auto accident? □No □Yes: *Date(s)*_____*Injury?*_____

Description of event: _____

Has the child every sustained an injury playing organized sports?

_____

_____

ABUNDANCE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE AGREEMENT (HIPPA)

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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 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. Andres Julia at (727) 201-2271 if 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

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices 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 an 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 Name_____ DOB_____

Patient Signature_____Date_____

Witness_____Date_____

JDD,DC 5/2011

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, WHILE OFFERING CONSIDERABLE BENEFITS, MAY ALSO PROVIDE SOME LEVEL OF RISK. IN EXTREMELY RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THESE CASES INCLUDE: STRAIN/SPRAIN INJURIES, IRRITATION OF EXISTING DISC CONDITION, AND FRACTURES, ETC. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC WHICH OCCURS AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED TO ASSESS YOUR SPECIFIC HEALTH AND SPINAL NEEDS. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NECESSARY OR IF FURTHER EXAMINATION IS NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT

Name_____**Signature**_____**Date**_____

Guardian Signature (For Minor)_____**Office Staff Signature**_____

TERMS OF ACCEPTANCE

TO PROMOTE THE MOST EFFECTIVE APPLICATION OF CHIROPRACTIC PROCEDURES AND THE STRONGEST POSSIBLE DOCTOR-PATIENT RELATIONSHIP, WE STATE THE FOLLOWING TO FACILITATE THE GOAL OF OPTIMUM HEALTH THROUGH CHIROPRACTIC.

TO THAT END, WE ASK THAT YOU ACKNOWLEDGE THE FOLLOWING POINTS REGARDING SERVICES WE PROVIDE:

1. CHIROPRACTIC IS A SPECIFIC, SEPARATE, AND DISTINCT PRACTICE AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH
2. CHIROPRACTIC SEEKS TO RESTORE NORMAL NERVE FUNCTIONING THROUGH THE ADJUSTMENT OF SPINAL SUBLUXATIONS TO MAXIMIZE THE INHERENT HEALING POWER OF THE BODY. SUBLUXATIONS ARE DEVIATIONS FROM NORMAL SPINAL STRUCTURES THAT INTERFERE WITH NORMAL NERVE PROCESSES.
3. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION(S) OF THE SPINE WITH THE SPECIFIC INTENT OF REPOSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE
4. CHIROPRACTIC DOES NOT SEEK TO REPLACE OR COMPETE WITH OTHER SPECIFIC HEALTH CARE PROFESSIONALS. THEY RETAIN RESPONSIBILITY FOR CARE AND MANAGEMENT OF MEDICAL CONDITIONS. WE DO NOT OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS.
5. YOUR COMPLIANCE WITH THE DOCTOR'S RECOMMENDATIONS IS ESSENTIAL TO ACHIEVING THE MAXIMUM HEALTH BENEFITS
6. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTOR ON ANY MATTER RELATED TO YOUR CARE AT THIS FACILITY, ITS NATURE, DURATION, OR COST, WHAT WE WORK TO MAINTAIN AS A SUPPORTING, OPEN ENVIRONMENT

BY SIGNING BELOW, I AM STATING THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature_____Date_____