Langston CHIROPRACTIC

Today's Date __ / __ / _____

Account # _____

Pediatric Patient Paperwork
Personal Information

Name _____ Date of Birth _____ Age ____ Male/Female
Address _____ City _____ State _____ Zip _____
Guardian(s) Name_____ Relationship _____
Home _____ Mobile _____ Mobile Carrier _____
Child's Social Security # _____ Weight _____ Height _____
Primary Care Physician _____ Doctor's # _____

Tell us how you heard from us!

My Employer _____ My Friend _____
Facebook _____ Email _____
Newspaper _____ Event _____
I live here _____ Other _____

Emergency Contact

Full Name _____ Phone # _____
Relationship _____

Financial Information

Are your complaints due to an Auto Accident or Workplace Injury? YES / NO

☐ Insurance ☐ Workers Comp ☐ Self Pay (CASH) ☐ Auto/Personal Injury ☐ Other_____

Primary Insurance

Name _____
Member ID _____ Group _____
Relation to insured: Self/Spouse/Parent/Child
Other than self:
Insured Name _____ Male/Female
Address _____
City_____State_____Zip_____
Phone_____DOB_____

Secondary Insurance

Name _____
Member ID _____ Group _____
Relation to insured: Self/Spouse/Parent/Child
Other than self:
Insured Name _____ Male/Female
Address _____
City_____State_____Zip_____
Phone_____DOB_____

Child's Current Problem:

Purpose of this visit: ☐Wellness Check-up ☐Injury or Accident ☐Other: _____
If your child is experiencing pain/discomfort, please identify where and how long _____
_____
When did the problem first begin? _____ Unknown / Gradual / Sudden
Ever had this problem before? Yes / No **If yes, when?** _____
Any bowel or bladder problems since this began? Yes / No
Have you seen any other doctors for this problem? Yes / No **Who?** _____
How long ago did you see someone for this problem? ___ Days / Weeks / Months / Years
How is the problem NOW? Improving / Stayed the Same / Worsening

Pregnancy Information:

How was your pregnancy?_____
Any pregnancy complications?_____
Did you take any medication during your pregnancy? _____
Other information _____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home
Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section
_____
Induced? Yes/No
Explain:_____
Medications during delivery?_____
Other information: _____

Post Birth Information:

Birth Weight:_____ **Birth Length**: _____
Breast Fed: Yes/No **How long?**_____ **Formula Fed** Yes/No **How Long?**_____
Introduced Solid Foods at _____ Months
Food Allergies or intolerances:_____
Doses of antibiotics/prescription drugs your child has taken: Past 6 months__ Total lifetime ___
Present prescription drugs/ dosage?_____
Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)
_____
List all surgical operations & years:
_____
Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No
If yes to either of the above, please describe:_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	NERVOUSNESS
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	EPILEPSY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	DISC PROBLEM
EAR INFECTIONS	ULCERS	SCIATICA	LUPUS	INFERTILITY
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	FIBROMYALGIA	GASTRIC REFLEX
TMJ	NUMBNESS IN HAND	NUMBNESS IN FEET	CHEST PAIN	OTHER:
NECK PAIN	MENSTRUAL DISORDER	LOW BACK PAIN	ARM PAIN	_____
MIGRAINES	HEART DISORDER	HIP PAINS	ADD/ADHD	_____
ANXIETY	STOMACH DISORDER	LEG PAINS	RHEUMATOID A.	_____
CHRONIC SINUS	BLADDER PROBLEMS	KNEE PAIN	OSTEOPOROSIS	_____

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Holding Head Up	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Tummy Time	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Nursing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sitting Up	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Crawling	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Standing Alone	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking Alone	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of patient who is a minor/child: _____ _____

I authorize Dr. Jacob Langston and Dr. Jenna Langston and any and all Langston Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Langston Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge and agree that Langston Chiropractic runs an open setting where incidental disclosures may occur. I agree that my personal health information may be used or disclosed for referrals to other health care providers with my permission, any billing or collection activities. I understand that the practice may leave messages on answering machines or make phone calls regarding scheduling of appointments, health benefit coverage and related discussion of care, including phone or mail notifications of any internal office promotions.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Langston Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Langston Chiropractic
Dr. Jacob Langston | Dr. Jenna Langston
Medical Information Release Form (HIPAA Release)

Name _____ Date of Birth __ / __ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed _____ Date __ / __ / ____