Dr. Steve Hom, D.C.
Family Chiropractor
Phone: (760) 487-8517
451 La Veta Ave. Encinitas CA 92024
www.indigodragoncenter.com

Pediatric Health History Form

Child's Name:_____Date:_____ Parent Names: _____

Sibling's Names & Ages: _____

Child's Age: _____ Birth date: (mm/dd/yyyy) _____ Sex: (circle) **M F**

Address: _____ City: _____

Zip Code: _____Email Address:_____

Phone:_____

Family doctor's name: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care? (circle) **Yes No**

If yes, who is your child's previous Doctor of Chiropractic? _____

The date of last visit: _____ The reason for the last visit:_____

WHY THIS FORM IS IMPORTANT: **Our focus is on assisting people to achieve excellence in health. This is a function of living a continuously more healthful life and improving your body's ability to adapt to your life choices. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can overwhelm the body's general adaptive potential and contribute to other health problems. Our clear goal is to help you realize what is possible for your health. Please complete this form as thoroughly as possible and the doctor will review it with you and have the greatest chance at helping you reach your goals.**

***Information collected and discussed on this form is strictly confidential and can only be shared with your consent.**

1. Current Health Concerns (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐

Health Concern :

_____

Other professionals seen for this condition:

_____

Results with that treatment?

_____

Recent tests done (list date): □ **Bloodwork** _____ □ **Urine** _____ □ **X-Rays** _____

Other:

_____

What have you tried to get rid of this problem that DID NOT work?

_____

Purpose for your child's visit: (check if applicable)

□ Crisis management
□ Early detection of problems
□ Wellness
□ Maximizing normal growth and development
□ Prevention
□ Other: _____

Please check if your child has had any of the following:

□ Dental problems
□ Headaches
□ Loss of concentration
□ Dizziness/Fainting
□ Loss of balance
□ Poor coordination
□ Vision changes
□ Ears buzzing
□ Ear pain/infections
□ Sinus congestion
□ Sore throats
□ Fevers
□ Allergies
□ Asthma
□ Bronchitis
□ Pneumonia

□ Difficulty breathing
□ Heart palpitations
□ Sleeping challenges
□ Fatigue
□ Depression
□ Irritability
□ Acid reflux
□ Constipation
□ Diarrhea
□ Bloating/gas
□ Urinary problems
□ Weight loss
□ Weight gain
□ Cold sweats
□ Face flushed
□ Skin rash/eczema

□ Weakness
□ Muscle cramps
□ Growing Pains
□ Numbness in extremities
□ Neck pain
□ Low back pain
□ Upper back pain
□ Light sensitivity
□ Colic
□ Torticollis
□ Breastfeeding Issues
□ Other:
_____
_____
_____

Which of the problems you have checked off is the worst?

_____

When did this problem begin? _____

Is this problem: (check) □ Occasional □ Frequent □ Constant □ Intermittent

Does problem radiate? (circle) **Yes No** (If Yes, where?)

_____

What makes this worse? _____ Better?_____

Is the problem worse during a certain time of the day? (circle) **Yes No** (If Yes, when?)

_____

What effect does this problem have on your child's body functions?

_____

_____

Does this interfere with the child's sleep? (circle) **Yes No**

Eating? **Yes No**

Daily routine? **Yes No**

Is this becoming worse? (circle) **Yes No**

When it is at its worst, how does it make your child feel?

_____

What have you done about it that has NOT worked?

_____

Describe any hospital stays:

_____

_____

Approximately how many times have antibiotics been prescribed and for what conditions?

_____

List any medications your child is currently

taking?_____

To summarize, what is your purpose for this appointment?

_____

_____

On a scale of 1 to 10, 10 being the highest, rate your commitment in helping us solve this problem:

_____

2. Birth History

Child's gestational age at birth? _____ Wks. Birth weight _____lbs. _____oz. Birth length _____in.

Was your child's birth: (check) □Home □Hospital □Birth Center □Other: _____

Was the birth considered: □Medical □Midwife

Duration of birth: _____ hours

Was child born: □Cephalic (head first) □ Breech (feet first)

Were there any complications? (circle) **Yes No** (If yes, please explain)

_____As

sistances used during delivery: (check) □ Forceps □ Vacuum □ Extraction □ C-section □ Episiotomy

Was labor: (check) □ Spontaneous □ Induced

Were medications or epidurals given to the mother during birth? (circle) **Yes No**

_____

APGAR score: at Birth _____/10, after 5 minutes_____/10

Is there anything else we need to know about the birth? _____

My child has been vaccinated: (circle) **Yes No** If Yes, normal or alternative schedule? _____

Tell us about any vaccinations your child has had: _____

_____

Any reactions to any of these? _____

_____

Were you told that you had a choice in vaccinating your child? (circle) **Yes No**

Would you like information on the "other side" of this issue? (circle) **Yes No**

3. Growth & Development

Was the infant alert and responsive within 12 hours of delivery? (circle) **Yes No** (If no, please explain)

_____

At what age(s) did the child:

Respond to Sound ____	Sit alone ____	Vocalize ____
Follow an object ____	Teethe ____	Walk ____
Hold up head ____	Crawl ____	

Does your child sleep: (check) □ Front □ Back □ Side

Do you consider your child's sleeping pattern normal? (circle) **Yes No**

How many hours per day? ____ (If no, please explain) _____

4. Physical Stressors

Any trauma(s) to the mother during pregnancy? (i.e. falls, accidents, etc.) (circle) **Yes No** (If yes, please explain) _____
Any evidence of birth trauma to the infant? (check if applicable)

- □ Bruising
- □ Odd-shaped head
- □ Cord around neck
- □ Stuck in birth canal
- □ Fast or excessively long birth
- □ Respiratory depression
- □ Other: _____ _____ _____

Any falls from couches, beds, changing tables, etc.? (circle) **Yes No** (If yes, please explain) _____

_____

Any traumas resulting in bruises, cuts, stitches or fractures? (circle) **Yes No** (If yes, please explain)

_____An

y hospitalizations or surgeries? (circle) **Yes No** (If yes, please explain)

_____

Any sports played? _____

Is a school backpack used? (circle) **Yes No**

How much tummy time does/did your baby do per day? (hrs.) _____

Did he/she like it? (circle) **Yes No**

5. Chemical Stressors

Was this child breast-fed? (circle) **Yes No** If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____

Began solid foods at what age: _____ Types of solid foods: _____

Food/liquids intolerance? (circle) **Yes No** Type: _____

Is your child on or have taken any medications? (circle) **Yes No**

During the mother's pregnancy? (circle) **Yes No** If yes, what were/are they?

_____

_____

Did the mother smoke? (circle) **Yes No** Drink alcohol? (circle) **Yes No**

Any illnesses during the pregnancy? (circle) **Yes No** (If yes, please explain) _____

_____An

y supplements taken during pregnancy? (circle) **Yes No** (If yes, please explain) _____

_____

Any ultrasounds? (circle) **Yes No** How many: _____ Reasons for being done: _____

_____

Any invasive procedures during pregnancy (i.e. amniocentesis, Chorionic villi sampling, etc.?)

(circle) **Yes No** (If yes, please explain) _____

Any pets at home? (circle) **Yes No** Any smokers in the home? (circle) **Yes No**

Any antibiotics given? (circle) **Yes No** (If yes, please explain) _____

Is the diet organic? (circle) **Yes No**

Do you use 'green products' in your home for cleaning? (circle) **Yes No**

How often do they receive processed foods, white sugar, gluten (flour), and dairy in their diet? (check if applicable)

- □ Never
- □ Special occasions
- □ Weekends
- □ Few times per week
- □ Daily
- □ Nearly each meal

Are you aware of the impact of nutrition on children's behavior? (circle) **Yes No**
Would you like information regarding nutrition for you child? (circle) **Yes No**

6. Psychosocial Stressors

Any difficulties with lactation? (circle) **Yes No** (If yes, please explain) _____

Any problems with bonding? (circle) **Yes No** (If yes, please explain) _____

Any behavioral problems? (circle) **Yes No** (If yes, please explain) _____

Any inattention? (circle) **Yes No** (If yes, please explain) _____

Any hyperactivity or restlessness? (circle) **Yes No** (If yes, please explain) _____

Any compulsiveness? (circle) **Yes No** (If yes, please explain) _____

Any difficulties at daycare or school? (circle) **Yes No** (If yes, please explain) _____

Any challenges with learning deficiencies? (circle) **Yes No** (If yes, please explain) _____

_____

Any night terrors, sleep walking, difficulty sleeping? (circle) **Yes No** (If yes, please explain) _____

_____An

y prolonged temper tantrums or separation anxiety? **Yes No** (If yes, please explain) _____

_____

Is the child in daycare? (circle) **Yes No** If yes, age of child when began daycare? (yrs. old) _____

Is there a nanny or regular sitter during the day if both parents work (circle) **Yes No N/A**

Is the child home schooled? (circle) **Yes No** by whom? _____

Average number of hours of TV per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? (circle) **Yes No** How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? (circle) **Yes No** (If no, please explain): _____

_____

In 6-12 months, if you could have anything for your child's health, what would you want? List 3 goals:

1. _____
2. _____
3. _____

7. Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

Condition	Father	Mother	Spouse	Siblings		Children			
	Age	Age	Age	Age	Age	Age	Age	Age	Age
ADHD									
Allergies									
Arthritis									
Asthma									
Autism									
Back Trouble									
Bed Wetting									
Bursitis									
Cancer									
Chest Pain									
Colic									
Constipation									
Crohn's Disease									
Depression									
Diabetes									
Diarrhea									
Disc Problems									
Down Syndrome									
Ear Infection									
Emotion Issues									
Emphysema									
Epilepsy									
Headaches									
Migraines									
Heartburn									
Heart Trouble									
High Blood Press									
IBS									
Indigestion									
Infertility									
Insomnia									
Kidney Trouble									
Neck Pain									
Neuritis									
Nervousness									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Other									

Our Fee Structure

Please note our office fees for your initial visit include:

Consultation	Complimentary
Examination + scans	$249.00 *(Referred Patients $149.00)*
X-rays (if applicable)	*$100.00*
	(referral to Imaging Healthcare Specialists)
TOTAL	**$149.00 - $349.00**

Please let us know if you, or you spouse is active duty military or veteran. As a thank you to our service members, we offer an additional 10% discount on all regular visit rates.

* Following your initial visit, subsequent family members' initial appointments are subject to the discounted rate of $100 per visit (including consultation, examination and scans).

SIGNATURE: _____

DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

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Your Informed Consent

In order for my health professional, as indicated below, to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so, by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not, is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my interests.

We would like all of our new patients to understand that Chiropractor's possess the lowest malpractice insurance premiums of all the health care professions in the world. Chiropractic care maintains significantly less risk compared to traditional medical, drug and surgical care professions, which account for approximately 200,000 annual deaths in North America alone. Chiropractic is your safest option in the healthcare system.

Although Chiropractic is reported to be the safest health care system in the world, we feel that it is responsible to let you know:

a. *Risk of stroke is reported to be 1 in 5-8 million and the cause has yet to be determined.*
b. *While extremely rare, there have been reports of ligament sprains and even rib fractures reported.*
c. *There have been rare reports of disc injuries, although no clinical scientific study has ever demonstrated chiropractic care to be the cause.*

I have read and understand the above consent and have had the opportunity to discuss it with my chiropractor.
I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for my family and me.

Your Name: _____ Date: _____

Your Signature: _____

Signature of Parent or Guardian: _____

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Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.
Stephen M. Hom Chiropractic, INC.
This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Stephen M. Hom Chiropractic, INC. to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Stephen M. Hom Chiropractic, INC. to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Stephen M. Hom Chiropractic, INC. contacts me by phone, I give them permission to leave a voice mail.
- I give permission to Stephen M. Hom Chiropractic, INC. to use my photograph marketing materials such as their brochure, website, social media and ads in print media.
- I give permission to Stephen M. Hom Chiropractic, INC. to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give Stephen M. Hom Chiropractic, INC. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Stephen M. Hom Chiropractic, INC. permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Stephen M. Hom Chiropractic, INC. for Healthy Families plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or acted in reliance on your authorization.
You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Stephen M. Hom Chiropractic, INC. The written notice must contain the following information:

1.Your name
2. Social Security number
3. Date of Birth
4. A clear statement of your intent to revoke this authorization
5. The date of your intent to revoke this authorization and your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Stephen M. Hom Chiropractic, INC. for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this **authorization**. If I refuse to sign this **authorization**, Stephen M. Hom Chiropractic, INC. will not refuse to provide treatment however, it will not be possible for Stephen M. Hom Chiropractic, INC. to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Stephen M. Hom Chiropractic, INC. will be unable to contact me 3) all contact with Stephen M. Hom Chiropractic, INC. Stephen M. Hom Chiropractic, INC. regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): _____ DOB:_____

Patient's Signature: _____ Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):

Signature:

Description of Representative's Authority to Act on Patient's Behalf:

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Patient Birth Records Release

I, _____, Parent (or legal guardian) of the below mentioned child, hereby authorize and direct _____ to release the records relating to the birth of _____, to Dr. Steve Hom at Stephen M. Hom Chiropractic, INC. noted below.

Date of Birth: _____

May this signed consent form be your good authority to do so.

***Parent (or legal guardian) Signature*: _____ *Date:* _____**

Indigo Dragon Center For Health and Wellbeing
Steve M. Hom, DC
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Thank You!