GOWER FAMILY CHIROPRACTIC - PEDIATRIC HISTORY FORM (11-17 YRS)

Patient Information

Name: _____ Date: _____
Date of birth: _____ Age:_____ Sex: ☐ Male ☐ Female
Parent/Guardian's name(s): _____
Street address: _____
City: _____ State:_____ Zip code: _____
Email address: _____
Home phone: _____ Cell phone: _____
Insurance Provider/ID#: _____
_____
How did you hear about our office? _____

Patient History

How would you describe the pregnancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe infancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe childhood? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
If you answered anything but normal, why? _____
_____
_____

How would you describe overall physical development?
☐ Above average ☐ Typical ☐ Behind schedule
How would you describe overall mental development?
☐ Above average ☐ Typical ☐ Behind schedule

Any childhood illnesses/diseases? _____
_____
Any surgeries? _____
_____
Any accidents? _____
_____

Has your child been vaccinated? Yes/No
If yes, which ones? _____
Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No

Has your child been on antibiotics? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins? Yes/No
If yes, how often and what purpose? _____
Is there anything else significant in patient's health history the Doctor should know?
_____
_____

Patient Name: _____**Date:** _____

Health & Wellness

What is the reason for your visit today? ☐ Wellness Check-Up ☐ Other: _____
If other, how long has this been a concern? _____
What do you think has caused this problem: _____
Do the symptoms radiate to anywhere else:_____
Please rate the pain on a scale of 0 - 10 (*0 = no pain, 10 =worst pain imaginable*): _____
How often does your child experience these symptoms: (Percentage of the Day)
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
Are these symptoms: ____Getting Worse ___Staying the Same ___Getting Better
Are these symptoms: Pain Numbness Tingling Burning Stabbing Achy
Weakness Stiffness Dull Sharp Throbbing Other _____
Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always
What makes the pain worse: _____
What makes the pain better: _____
Has anything been done already to address this concern? _____
_____

Are any of the following symptoms present?

Acne/Skin problems	Depression/ Anxiety	Repeated colds/infections
ADD/ ADHD	General fatigue	Scoliosis
Allergies	Growing pains	Seizures
Asthma	Headaches/Migraines	Sleeping problems
Autism	Irritability/Moodiness	Stomach pains
Bedwetting	Learning difficulties	Tonsillitis

Other _____

Does your child participate in any athletic extra-curricular activities? Yes/No
If yes, which ones? _____
Rate your child's diet: ☐ Well-balanced ☐ Average ☐ High sugar/processed foods
Does your child consume artificial sweeteners? Yes/No
Rate your child's exercise: ☐ Frequently ☐ Sometimes ☐ Never
How many glasses of water does your child drink? _____/day
Number of hours your child sleeps? _____hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor
Rate their general mood: ☐ Happy ☐ Melancholy ☐ Depends on the day

Height: _____ ft _____in Weight: _____ lbs Handedness: Right/Left

Do any family members suffer from?

Arthritis	Scoliosis	Spinal Stenosis	High Blood Pressure	
Diabetes	Stroke	Heart Disease	Cancer	Osteoporosis

Other _____

Has your child ever been to a chiropractor before and did it help? _____
Is there anything else you'd like the Doctor to know? _____
_____

Parent/Guardian Signature: _____ Date: _____
Patient's Signature: _____ Date: _____

Patient Name: _____**Date:** _____

Gower Family Chiropractic, LLC
Alicia Gower, D.C.
936 B South Broadway
Pennsville, NJ 08070

INFORMED CONSENT

I have received information about my (or my child's) condition and the proposed treatment plan as well as alternative courses of care; the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment. I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to: muscles strains and sprains, fractures, bruising, dislocation, disc injuries, and stroke. I understand that chiropractic care may cause a temporary increase in soreness in the area being treated, which will almost always resolve with time but should be reported to the doctor. Any change in symptoms or reaction to care beyond mild soreness should be reported to the doctor immediately. My doctor has responded to all my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest. I understand that, as with every healthcare system, there is no guarantee of results or cure for any symptom, disease, or condition and if I do not improve, I may be referred to another physician whom the doctor feels may help with my situation. By signing below I consent to chiropractic treatment. If signing for a minor, I attest that I am the legal guardian and therefore have the power to consent to chiropractic treatment of the minor.

Patient Name (Print): _____

Patient Date of Birth: _____/_____/_____

Legal Guardian Name (Print): _____

Signature of Legal Guardian: _____

Date: _____

Patient Name: _____**Date:** _____

Gower Family Chiropractic, LLC
Alicia Gower, D.C.
936 B South Broadway
Pennsville, NJ 08070

ASSIGNMENT OF BENEFITS

I, _____, the insured and/or beneficiary of the policy or policies of the insurance providing medical benefits to me, do hereby authorize you to pay directly to the above named company, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company: _____

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due it should sums not be paid within the legally prescribed or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider including attending any type of Deposition, Arbitration, or Court proceeding. I understand that if I fail to cooperate with legal counsel, I may be held personally responsible to the medical provider for any expenses not covered by the responsible insurance carrier. I realize that I am financially responsible for charges not covered by this assignment and charges not covered by insurance carrier. Payment, in whole or part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward the said endorsed checks to the provider upon receipt of the same. It is understood and agreed that should the undersigned patient not forward any benefits to the provider, the provider does maintain the right to request said checks from the patient and initiate any and all collection efforts. If such action is taken by the provider, the undersigned agrees to be responsible for any and all benefit checks received, plus and all collection costs incurred including attorney fees and all Court costs.

The undersigned patient understands that if they have any insurance other than: Medicare, Horizon BC (excluding Horizon NJ Health), Amerihealth, Amerihealth Administrators, Aetna (excluding Aetna Better Health), United (excluding Community Plan), and select other Blue Cross plans; this provider is out of network and benefits will be based on out of network status. This may result in higher out-of-pocket costs for the patient.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved and hereby release this clinic of any consequence thereof.

Primary Insured: _____ DOB: ____/_____/_____

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑Child/Dependent

Patient Name: _____

Legal Signature: _____

(if minor, parent or legal guardian must sign)

Date: _____

Patient Name: _____Date: _____

Gower Family Chiropractic, LLC
936 B South Broadway Pennsville, NJ 08070

HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. We will text, call and, if necessary, leave voicemail messages regarding appointments or other office information at the phone number you provide us. You have the right to request that we do not call you, do not text you, or that we do not leave you messages. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case. Additionally, our office utilizes an "open adjusting" treatment room. If you would prefer a private room, please inform the staff.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions. If you voluntarily provide us with the person who referred you to our office, you are giving us permission to send that person a thank you card with your name included. You have the right to request that we do not disclose this information.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity

with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. **We will charge a reasonable fee for providing a copy of your health records**, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion, within thirty (30) days.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to
PRIVACY OFFICER, Gower Family Chiropractic, 936 B South Broadway Pennsville, NJ 08070

Signature below indicates you have received this Notice of Privacy Practices:

Print Patient Name: _____
Parent/Guardian Signature: _____
Date: _____

Patient Name: _____**Date:** _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you. but please just mark the box which MOST CLOSELY describes your problem.

Section 1 - Pain intensity

□ I have no pain at the moment
□ The pain is very mild at the moment
□ The pain is moderate at the moment
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment
□ The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)

□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self care.
□ I do not get dressed, I wash with difficulty and stay in bed

Section 3 - Lifting

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can lift very light weights.
□ I cannot lift or carry anything at all.

Section 4 - Reading

□ I can read as much as I want to with no pain in my neck.
□ I can read as much as I want to with slight pain in my neck.
□ I can read as much as I want with moderate pain.
□ I can't read as much as I want because of moderate pain in my neck.
□ I can hardly read at all because of severe pain to my neck.
□ I cannot read at all.

Section 5-Headaches

□ I have no headaches at all.
□ I have slight headaches which come infrequently
□ I have slight headaches which come frequently
□ I have moderate headaches which come infrequently.
□ I have severe headaches which come frequently
□ I have headaches almost all the time.

_____

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score____ x 2) / (_____Sections x 10) = _____ %ADL

Section 6 - Concentration

□ I can concentrate fully when I want to with no difficulty.
□ I can concentrate fully when I want to with slight difficulty.
□ I have a fair degree of difficulty in concentrating when I want to.
□ I have a lot of difficulty in concentrating when I want to.
□ I have a great deal of difficulty in concentrating when I want to.
□ I cannot concentrate at all.

Section 7—Work

□ I can do as much work as I want to.
□ I can only do my usual work, but no more.
□ I can do most of my usual work, but no more
□ I cannot do my usual work.
□ I can hardly do any work at all.
□ I can't do any work at all.

Section 8 - Driving

□ I drive my car without any neck pain.
□ I can drive my car as long as I want with slight pain in my neck.
□ I can drive my car as long as I want with moderate pain in my neck.
□ I can't drive my car as long as I want because of moderate pain in my neck.
□ I can't drive my car at all.

Section 9 - Sleeping

□ I have no trouble sleeping.
□ My sleep is slightly disturbed (less than 1 hr. sleepless)
□ My sleep is moderately disturbed (1 -2 hrs. sleepless).
□ My sleep is moderately disturbed (2-3 hrs. sleepless)
□ My sleep is greatly disturbed (3-4 hrs. sleepless).
□ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

□ I am able to engage in all my recreation activities with no neck pain at all.
□ I am able to engage in all my recreation activities, with some pain in my neck. ,
□ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
□ I am able to engage in a few of my usual recreation activities because of pain in my neck.
□ I can hardly do any recreation activities because of pain in my neck.
□ I can't do any recreation activities at all

Comments_____

Reference' Vernon. Mior JMPT 1991: **14(71:409-15)**

Patient Name: _____**Date:** _____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 - Pain Intensity

- □ I can tolerate the pain without needing to use painkillers.
- □ The pain is bad but I can manage without taking painkillers.
- □ Painkillers give complete relief from pain.
- □ Painkillers give moderate relief from pain.
- □ Painkillers give very little relief from pain.
- □ Painkillers have no effect on the pain and I do not use them

Section 2 - Personal Care (Washing, Dressing, etc.)

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self care.
- □ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift very light weights.
- □ I cannot lift or carry anything at all.

Section 4 - Walking

- □ Pain does not prevent me from walking any distance.
- □ Pain prevents me from walking more than one mile.
- □ Pain prevents me from walking more than one-half mile.
- □ Pain prevents me from walking more than one-quarter mile
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- □ I can sit in any chair as long as I like
- □ I can only sit in my favorite chair as long as I like
- □ Pain prevents me from sitting more than one hour.
- □ Pain prevents me from sitting more than 30 minutes.
- □ Pain prevents me from sitting more than 10 minutes.
- □ Pain prevents me from sitting almost all the time

Scoring: Questions are scored on a vertical scale of 0-S. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score_____x2) / (_____Sections x 10) = _____%ADL

Section 6 - Standing

- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives extra pain.
- □ Pain prevents me from standing more than 1 hour.
- □ Pain prevents me from standing more than 30 minutes.
- □ Pain prevents me from standing more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7 - Sleeping

- □ Pain does not prevent me from sleeping well.
- □ I can sleep well only by using tablets (pain meds).
- □ Even when I take tablets I have less than 6 hours sleep.
- □ Even when I take tablets I have less than 4 hours sleep
- □ Even when I take tablets I have less than 2 hours sleep
- □ Pain prevents me from sleeping at all.

Section 8 - Social Life

- □ My social life is normal and gives me no extra pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests i.e. dancing.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to my home.
- □ I have no social life because of pain.

Section 9 - Traveling

- □ I can travel anywhere without extra pain.
- □ I can travel anywhere but it gives me extra pain.
- □ Pain is bad but I manage journeys over 2 hours.
- □ Pain is bad but I manage journeys less than 1 hour.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to the doctor or hospital.

Section 10 - Changing Degree of Pain

- □ My pain is rapidly getting better.
- □ My pain fluctuates but overall is definitely getting better.
- □ My pain seems to be getting better but improvement is slow at the present.
- □ My pain is neither getting better nor worse.
- □ My pain is gradually worsening.
- □ My pain is rapidly worsening.

Comments _____

Reference: Fasbank. Physiotherapy 1981:66<8): 271-3, Hudson-Cook. In Roland. Jenner (eds.). Back Pain New Approaches To Rehabilitation & Education Manchester Univ Press. Manchester 1989M87-204