WAGNER Chiropractic
A Center For Healing

2775 S. Bay Street
Eustis, FL 32726

Office 352-589-5443

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: _____ Date of Birth: _____/_____/_____ Gender: M F

Reason for this visit: _____

Age: _____ Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Length: _____ # of Siblings: _____

Childs Congenital Anomalies/Defects: _____

Family History of Congenital Anomalies/Defects: _____

Type of Birth (circle all that apply): Normal Vaginal Forceps Breech Cesarean

Birthing Location: Home Birth Birthing Center: _____ Hospital: _____

Pregnancy History / Problems During Pregnancy: _____

_____

Delivery & Birth History / Problems During Labor & Delivery: _____

_____

APGAR Scores: _____ _____ Was there presence at birth of: _____ Jaundice (yellow) _____ Cyanosis (blue)

Infant Feeding: Breast: _____ # of Months: _____ Bottle: _____ # of Months: _____

Formula: _____ # of Months: _____ Brand(s): _____

Number Of Hours of Sleep Per Night: _____ Quality of Sleep (circle): Good Fair Poor

Immunization History: _____

Developmental History - At what age did the child:

___ mo/yrs Respond to sound
___ mo/yrs Follow an object with his/her eyes
___ mo/yrs Hold head up
___ mo/yrs Crawl
___ mo/yrs Sit unaided
___ mo/yrs Stand unaided
___ mo/yrs Walk unaided

Childhood Diseases (check all that apply):

___ Chicken Pox ___ Mumps
___ Measles ___ Rubella
___ Rubeola ___ Whooping Cough
Other:_____

Has this child ever suffered from (check all that apply):

__ Dizziness __ Bed wetting __ Tuberculosis __Blood Disorders __ Chronic earaches
__ Diabetes __ Digestive Disorders __ Headaches __ Heart trouble __ "Growing pains"
__Arthritis __ Fainting __ Hyperactivity __ Hypertension __ Allergies
__ Neuritis __ Neck problems __ Convulsions __ Asthma __ Constipation
__ Anemia __ Joint problems __ Rheumatic Fever __ Sinus trouble __ Diarrhea
__ Poor appetite __ Backaches __ Arm problems __ Walking problems __ Behavioral problems
__ Paralysis __ Broken bones __Leg problems __ Muscle jerking
__ Colds/Flu __ Stomach Aches __Ruptures/Hernias Other:_____

Present History & Allergies: _____

_____

Surgeries: _____ Accidents:_____ Medications:_____

Family History: _____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Wagner Chiropractice , P.A.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative — Printed Name of Patient

_____ _____

Date of Signing — Description of Personal Representative's Authority