burien wellness

You were born to be healthy.

PEDIATRIC PATIENT INFORMATION

Date _____

Name _____ _____ _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthday_____/_____/_____

1st Parent / Guardian Name _____

Relationship _____

Contact Number _____

Email _____

2nd Parent / Guardian Name_____

Relationship _____

Contact Number _____

Email _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you?_____

_____

HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness ☐ Physical Complaint ☐ Accident

☐ Other, Please describe: _____

PRENATAL HISTORY

Complications during pregnancy? ☐ No ☐ Yes

If yes, what complications did you experience? _____

_____

Maternal vaccinations during pregnancy? ☐ No ☐ Yes

If yes, which vaccinations? _____

_____

Maternal medications during pregnancy? ☐ No ☐ Yes

If yes, what medications? _____

Maternal substance use? ☐ None ☐ Alcohol ☐ Tobacco

☐ Other: _____

Illness or infection during pregnancy? ☐ No ☐ Yes

If yes, please describe _____

_____

Ultrasounds or other testing? ☐ No ☐ Yes

_____

BIRTH HISTORY

Place of Birth	Birth Provider	Type of Birth	Interventions During Labor	
☐ Birth Center	☐ Midwife	☐ Vaginal (Vertex)	☐ Pain Medication	☐ Epidural
☐ Home	☐ OB-GYN	☐ Vaginal (Breech)	☐ Pitocin	☐ Vacuum Extraction
☐ Hospital	☐ Other	☐ C-Section	☐ Forceps	☐ Twisting / Pulling

Was labor induced? ☐ No ☐ Yes If yes, why?_____

Did the child experience: ☐ Misshapen skull ☐ Torticollis ☐ Colic ☐ Other: _____

APGAR score: _____ ☐ Unknown

CHILDHOOD HISTORY

Has your child been vaccinated? ☐ No ☐ Yes

Reason: ☐ Informed Consent ☐ Pediatrician Recommended ☐ I didn't know I had a choice

Did your child have any negative reaction to the vaccines? ☐ No ☐ Yes

If yes, what did they experience? _____

Was this reaction reported? ☐ No ☐ Yes

Does your child have food or seasonal allergies? ☐ No ☐ Yes

If yes, please describe _____

Has your child been on any medications, including antibiotics? ☐ No ☐ Yes

If yes, how often and for what purpose? _____

Has your child ever been hospitalized? ☐ No ☐ Yes, for _____

Does your child participate in any athletics or other extra-curricular activities? ☐ No ☐ Yes

If yes, which and how often? _____

How is your child's diet?
- ☐ Well-Balanced
- ☐ Average
- ☐ Below Average/Highly Processed

How is your child's sleep quality?
- ☐ Excellent
- ☐ Fair
- ☐ Poor

Child's average nightly sleep?
- ☐ >12 Hours
- ☐ 9-12 Hours
- ☐ 6-9 Hours
- ☐ < 6 Hours

BABY / TODDLER (0-5 Years)

Check the box beside any condition your child has had. **Please circle the condition(s) which bother your child the most.**

- ☐ Jaundice
- ☐ Anemia
- ☐ Cyanosis
- ☐ Seizures
- ☐ Tonsillitis
- ☐ Frequent ear infections
- ☐ Colic
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Sleeping problems
- ☐ Frequent fevers
- ☐ Frequent colds/viral infections
- ☐ Reflux
- ☐ Fall from a height <4 feet
- ☐ Fall from a height >4 feet
- ☐ Fall down stairs
- ☐ Use of a soft structured carrier
- ☐ Car accident
- ☐ Other: _____

CHILD / TEEN (6-17 Years)

Check the box beside any condition your child has had. **Please circle the condition(s) which bother your child the most.**

- ☐ Fall from a height <4 feet
- ☐ Fall from a height >4 feet
- ☐ Sports accident
- ☐ Car accident
- ☐ Stomach pain/indigestion
- ☐ Hyperactivity/ADHD
- ☐ Autism/Asperger's
- ☐ Leg/knee pain
- ☐ Arm/shoulder pain
- ☐ Growing pains
- ☐ Learning difficulties
- ☐ Bed-wetting
- ☐ Asthma
- ☐ Allergies
- ☐ Headaches/migraines
- ☐ Anxiety/depression
- ☐ Scoliosis
- ☐ Severe menstrual cramps
- ☐ Other: _____

Is there anything else you would like the doctor to know? _____

_____

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Authorization to Treat a Minor

I, _____, the undersigning parent/guardian having legal custody or guardianship of _____, a minor, and do hereby authorize, request and direct the staff and doctors at Burien Wellness to perform any examination, chiropractic diagnosis or treatment which is deemed necessary.

Patient's Full Name:

_____

Parent/Guardian's Full Name:

_____

Parent/Guardian's Signature:

_____ Date: _____

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HIPAA (Health Insurance Portability & Accountability Act)

Re: Appointment Calls, Open Room Adjusting & Health Care Information

The doctors and staff at Burien Wellness may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member**. By signing this form, you are giving us authorization to contact you with these reminders and information.**

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

At Burien Wellness we believe it is important that all of your care professionals work together for your benefit. By signing this release you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Burien Wellness.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvements or lack there of may be discussed during your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This authorization will expire seven years after the date on which you last received services at Burien Wellness.

I authorize Burien Wellness to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Name (print): _____

Patient Signature: _____

(*or parent/guardian if under 18*)

Parent/Guardian Name (please print) _____

Date: _____