Patient History

Legal Name: _____ **Date of Birth:** _____/_____/_____

Has your child complained of:

____ Low Back Pain ____ Pain between the shoulders ____ Neck Pain ____ Tension

____ Growing Pains ____ Ear Pain ____ Headaches ____ Allergies

Have you noticed your child:

____ Sleeping Poorly ____ Walking only on tippy toes ____ Walks with one foot flared out or in

____ Trips frequently ____ Nurses poorly on one sid ____ Head flatness or bald spot on infant

____ Bedwetting ____ Carries heavy bookbag ____ Pants are longer on one leg or clothes twist

____ Has frequent fevers ____ Constipation sturggles ____ Head turns one way in carseat/bed

____ Has difficulty learning ____ Has digestive problems ____ Extra fussy or seems uncomfortable

Please describe any other concerns you may have:

_____

_____

_____

_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Family History

Legal Name: _____ Date of Birth: _____/_____/_____

Please mark all current health problems of family members.

Condition	Self	Father Age [ ]	Mother Age [ ]	Brother(s) Age(s) [ ]	Sister(s) Age(s) [ ]	Children Age(s) [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

Past Surgeries? Yes / No If Yes, please list: _____

Is your child currently taking any medications? Yes / No

If Yes, Please list: _____

Any allergies? Yes / No If Yes, please list: _____

Staff Only:			
Height (inches)	**Weight**	**Pulse**	**BP (L / R)**

Demographics

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ SS#: _____

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____

General Information

Family Physician: _____ Physician's Location: _____

Physician's Phone #: _____ May we send our findings to them? Yes / No

Emergency Contact: _____ Phone: _____ Relation: _____

Do you have Insurance? Yes / No
If Yes, please fill in below:

	Primary Insurance	Secondary Insurance
Company		
Policy #		
Group # (Except Medicare)		
Patient's Relation to Policy Holder	[__] Self [__] Spouse [__] Child	[__] Self [__] Spouse [__] Child
Policy Holder's Name		
Policy Holder's DOB		
Policy Holder's Address		

If patient is a minor or under a guardianship order as defined by State Law:

_____ _____
Name of Parent/Guardian Signature of Parent/Guardian

Dated this _____ day of _____, 20____.

Patient Acknowledgement & Receipt of Notice of Privacy Practices Pursuant to HIPAA & Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

_____
Patient Name

If patient is a minor or under a guardianship order as defined by State Law:

_____ _____
Name of Parent/Guardian Signature of Parent/Guardian

Dated this _____ day of _____, 20____.

HIPAA AUTHORIZATION FOR FAMILY/FRIENDS

I, _____, give permission to DeTray Chiropractic Center providers and payers to disclose and release my health information to:

Names:	Relationship:
_____	_____
_____	_____
_____	_____

Health information to be disclosed: My complete health record (including but not limited to diagnoses, x-rays, prognosis, treatment, and billing for all conditions). This information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultations, for claims payment purposes, or related reasons. This authorization shall be effective all past, present, and future periods unless I revoke it. (Note: You may revoke this authorization in writing at any time)

_____ _____
Patient Signature Date of Authorization

_____
If patient is a minor, name of the individual giving this authorization

Informed Consent

The primary treatment used by doctors of chiropractic is the spinal manipulation or adjustment.

- **The nature of the chiropractic adjustment:**
  - I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.
- **The material risks inherent in chiropractic adjustment:**
  - As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, factures, strains and dislocations, Bernard Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separations. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.
- **The probability of those risks occurring:**
  - Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray. Stroke has at most a one-in-a-million outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Patient Name	Date
Signature	Signature of Parent or Guardian (if a minor)

Privacy Policy

This privacy policy discloses the privacy practices for www.detraychiropractic.com. This privacy policy applies solely to information collected by this web site. It will notify you of the following:

1. What personally identifiable information is collected from you through the web site, how it is used and with whom it may be shared.
2. What choices are available to you regarding the use of your data.
3. The security procedures in place to protect the misuse of your information.
4. How you can correct any inaccuracies in the information.

Information Collection, Use, and Sharing

We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.

We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than as necessary to fulfill your request, e.g. to ship an order.

Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to this privacy policy.

Your Access to and Control Over Information

You may opt out of any future contacts from us at any time. You can do the following at any time by contacting us via the email address or phone number given on our website:

- See what data we have about you, if any.
- Change/correct any data we have about you.
- Have us delete any data we have about you.
- Express any concern you have about our use of your data.

Security

We take precautions to protect your information. When you submit sensitive information via the website, your information is protected both online and offline.

While we use encryption to protect sensitive information transmitted online, we also protect your information offline. Only employees who need the information to perform a specific job (for example, billing or customer service) are granted access to personally identifiable information. The computers/servers in which we store personally identifiable information are kept in a secure environment.

Updates

Our Privacy Policy may change from time to time and all updates will be posted on this page.