Welcome to Funk Family Chiropractic

- Pediatric Case History -

Jason Funk D.C. – (402)934-3500

Dear New Patient - It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family!

Name ____________________________________ Today's Date ____________________ Date of Birth ___/___/____ Age________

Address ____City ____________________State_________Zip _________________

Parent/legal guardian name _______________________________ Work phone_________________________________Ext_________

Home phone _______________________ Cell_______________________ Email address ___________________________________

Social Security # _____-____-_______ Male/Female # of Siblings _________ Weight ________ Height_________

Reason for seeking chiropractic care: ____

____

Other Doctors seen for this condition ___Y ___N Dr.'s Name and prior treatment ____

Has your child ever suffered from: (Check all that apply)

__Numbness/Tingling/Pain in (Arm/Hands/Fingers) Right/Left/Both

__Numbness/Tingling/Pain in (Buttocks/Thighs/Legs/Feet/Toes) Right/Left/Both

__**Headaches/Migraines**	__Hip Pain R/L	__Neck Stiffness/Pain	__Back Stiffness/Pain
__Fractured Bones	__Arthritis	__**Frequent Colds/Flu**	__Diabetes
__Swollen Painful Joints	__Convulsions/Epilepsy	__Skin Problems	__Cancer
__High Blood Pressure	__Tremors	__Blurred Vision R/L	__Double Vision R/L
__Pain w/Cough / Sneeze	__Chest Pain	__Lung Problems	__**Ear Infection**
__Heart Problems	__Stroke	__Gall Bladder Problems	__Loss of Smell
__**Asthma**	__Kidney Trouble	__Loss of Balance	__Digestive Problems
__Dizziness/Vertigo	__Buzzing/Ringing in ears	__**Sinus Problems/Allergies**	__Nervousness/Anxiety
__Fatigue	__Depression	__Irritability/Mood Swings	__Tension/Stress
__Colon Trouble	__**Sleeping Problems**	__Recurring Infections	__ Anemia
__**Colic**	__**Bed Wetting**	__**Stomach Upset**	__HIV/AIDS
__Foot Problems	__Shortness of Breath	__Heartburn/Reflux	__Diarrhea/Const./Gas
__Cold Sweats	__Light Bothers Eyes	__Problems Urinating	__Jaw/TMJ Problems
__Cold Hands	__**"Growing" Pains**	__Ulcers	__Chemical Dependence

__Other ____

Family Health History: ____

Previous Chiropractor: ____ Date of last visit ____/____/__________

Reason for visit ____

Name of Pediatrician: ____ Date of last visit ____/____/__________

Reason for visit ____

Number of doses of antibiotics your child has taken: During past 6 months _______ Total during his/her lifetime ________

Number of doses of other prescription medications your child has taken: During the past 6 months ______ Total during his/her lifetime ______

Has your child ever had (circle all that apply): Chicken Pox Mumps Rubella Rubeola Whooping Cough Other _____________

Birthing Information: Birth weight ___________ Birth length ___________ APGAR Score ____________

(check all that apply to your child)

__ Long Delivery __Forceps __Suction __C-section __ Breech/Cephalic

__Home birth __Birthing Center __Hospital delivery __Labor induced __Medication during pregnancy/delivery

__Alcohol/ Cigarette use during pregnancy __Complications: ____

Developmental History: # of hours sleeping per night: ______________ Quality of sleep: Good Fair Poor

(At what age did your child begin to)

______Respond to Sound ______Sit up ______Respond to Visual Stimuli ______Hold Head Up

______Cross Crawl ______Stand Alone ______Walk Alone

Any developmental delays: ____Y ____N Describe: ____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie bed, changing table, stairs, etc) Was this the case with your child? ____Yes ____ No

Is/has your child ever been involved in a high impact or contact type sport? ____Yes ____No Type ___________________________

Has your child ever been involved in an auto accident? ____ Yes ____ No Reason/Date: __________________________________

Other traumas not described above? ____
Prior surgery: ____ Y ____N Type & Date: ____

Current Habits:
Check all that apply to your child

__ Healthy Foods	__ Junk Foods	__ Smoking	__ Exercise	__ Alcohol use
__ Teeth/jaw probs	__ Eye probs	__Hearing Probs	__ Poor Sleep	__ High Stress
__ Lack of focus	__ Poor grades	__Violence	__ Pop/soda	

Females Only:
*X-rays may be taken during the exam & x-rays can damage fetal development.
Is there any chance the patient might be pregnant? ____Yes ____No ____ Not sure
Age of first menstrual period: __________________________ Date of last menstrual period: ________________________________

Signature of guardian verifying patient is NOT pregnant: ____

Insurance:
Do you have medical insurance?: ___Y ___N Insurance Co. Name _____________________________________

Policy # ____ Ins Co Phone # :____

Insured's Name: _______________________________________ Relationship to patient: __________________________________

Insured's DOB: ____ Insured's SS #: ____

Insured's Employer: ____________________________________ Insured's Employee Phone # ______________________________

Your child will receive the best care that chiropractic has to offer. First, we will perform a spinal exam to determine the health of your child's spine If we find areas that need attention, gentle spinal adjustments will be performed to restore proper nerve supply and help your child get and stay as healthy as they were designed to be.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Dr. Jason Funk to administer chiropractic care to my child as he deems necessary. I understand that regardless of any implied insurance coverage, I am ultimately financially responsible for my account.

Guardian Name ________________________________

Guardian Signature ____ Date _________________________

PATIENT PRIVACY RIGHTS

This notice describes how chiropractic/medical information about you may be used and disclosed and how you can get access to this information. Review this material carefully.

In the course of your care as a patient at Funk Family Chiropractic Center, we may use or disclose personal and health-related information about you in the following ways:
*Your personal health information, including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your healthcare records as well as your billing records may be disclosed to another party such as an insurance carrier or your employer if they are or may be responsible for payment of services rendered to you.
*Your name, address, telephone number and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care or for other health-related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will NOT effect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted and/or required to use or disclose your health information without your consent to authorization in these circumstances: if we are providing healthcare services to you based on the orders of another healthcare provider; if we provide healthcare services to you in an emergency; if we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so; if there are substantial barriers to communicating with you but in our professional judgment we believe that you intend for us to provide care; if we are ordered by the courts or another appropriate agency. Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, advise us in writing of your preference. You have the right to inspect and/or copy your health information for 7 years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to use in writing. We are required by state & federal law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to this notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or you would like further information about our privacy policies and practices, please contact: Dr. Jason Funk, 17660 Wright Street, Suite 11, Omaha, Nebraska 68130. Phone (402)934-3500.

This office often uses an "open adjusting" environment for on-going patient care. All consultations, examinations and reports are done in a confidential setting. If you choose to not be adjusted in an open environment, other arrangements will be made for you.

This notice is effective August 1, 2006. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

Patient/Guardian Name: ____ Date: _________________________
**If you are a minor, your privacy rights sheet must be signed by a personal representative (parent or guardian).

<u>CHIROPRACTIC CLIENT CARE POLICY</u>

When a patient seeks chiropractic care and we accept that patient for care, it is essential that we are each working toward the same objective. We want you to know exactly what chiropractic care is all about and what it can offer you.

Chiropractic only has one goal. That is to remove vertebral subluxation. It is important that each patient understand both the objective and the method that will be used to attain it. This prevents confusion or misconception on the part of patient since chiropractic care is new to many people.

<u>Vertebral Subluxation</u>: A misalignment of one or more of the 24 vertebra in the spinal columns which causes altered nerve function and results in a lessening of the body's innate ability to express its highest health potential over time.

<u>Adjustment</u>: The specific manual application of light forces (by Dr. Funk) to help the body correct spinal nerve interference.

<u>Health</u>: A state of optimal physical, mental and social well-being, and not merely the absence of disease and infirmity.

We do not offer to diagnose or treat any disease other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will recommend that you seek the services of another healthcare professional who is qualified to work with the said condition.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of your body's innate self-healing capacity. Our only method to achieve this goal is specific, gentle chiropractic adjustments to correct vertebral subluxations.

I, ____________________________________, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction with the information above. I therefore accept chiropractic care on this basis.

____ _____________________________

(Signature) (Date)

<u>Office Policies & Procedures – Please read to make your visits more enjoyable!</u>

*Cell Phones & Pagers: Prohibited in our office – please turn them off as you arrive for each visit.

*Appointment Scheduling: Following your recommended care plan is vital to achieve maximum progress in minimum time. The benefits of each appointment build on the prior appointment, so keeping your appointments is VITAL for the restoration and maintenance of your health.

*Appointment Re-scheduling: If you need to change an appointment, you must call us in advance. Each appointment is a reserved time that we can offer to others should your schedule change. We ask that you reschedule your appointment within 48 hours of your original appointment to avoid lapses in care that can slow progress. We reserve the right to charge you $20 for EACH "no show, no call" appointment – *not payable by insurance or 3rd party.*

*Referral Policy: We welcome your kind referrals of friends and family. We are delighted to help everyone from babies to seniors to maximize their health and healing potential through our safe and gentle adjustments.