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| **Welcome to Lyphos Family Health!**  **Your child’s health history is important to us. Please fill out this form COMPLETELY.** | | | | | | |
| **Today’s Date:** | | | | | | |
| Patient First Name: | | | Patient Last Name: | | | |
| Parent/Guardian Name (s): | | | | | | |
| Relationship to Patient: | | | | | | |
| What does your child prefer to be called?: | | | | | | |
| Street Address: | | | | | | |
| City: | State: | | | | | Zip Code: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s Ph#: ( ) | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_’s Ph#: ( ) | | |
| Would you like us to send you a text message for your future appointment reminders?  ** Yes, Text Please! No Thank you, No Reminder needed.** | | | | | | |
| Email: | | | | | | |
| Date of Birth: / / | | Age: | | | | Sex:  Female  Male   Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact Name: | | | | | Relationship: | |
| Emergency Contact Phone #: ( ) | | | | | Secondary #: ( ) | |
| Primary Care Provider: | | | | | Phone: ( ) | |
| Primary Care Provider Address: | | | | | | |
| Who may we thank for referring you? | | | | | | |

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| **What school/daycare does the patient attend:** |

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| **If you know your child’s approximate height and weight please specify here** | Height: \_\_\_\_\_\_’\_\_\_\_\_\_” | Weight: \_\_\_\_\_\_\_\_\_lbs |

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| **Birth History** | | |
| ** Vaginal  C-Section** | Weeks gestation: | Birth Weight: |
| **Any concerns at birth or shortly after?:** | | |

**Patient Health Information Consent**

By signing below, I understand that I hereby authorize Blue Zone Health (hereafter “LFH”) to disclose my medical information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to LFH. I also authorize Lyphos Family Health to release all information necessary for the processing of insurance claims to Health Care Financing Administration (HFCA), its agents or any other insurance company to determine the benefits payable for related services. I understand that if I refuse to sign this consent for the purpose of treatment, payment and health care operations, the healthcare provider has the right to refuse to give care.

I understand that by authorizing this release of my medical records I also release LFH from all legal responsibility or liability that may arise from the release of these medical records. This authorization is valid until further notification to the contrary.

I acknowledge that I have been made aware of the privacy policy of this office, as it pertains to the privacy and confidentiality of my medical records. If I would like to have a more details concerning the privacy of my Patient Health Information I can ask to read the HIPPA NOTICE that is available to me at the front desk before signing this consent.

**HIPAA Disclosure**

In an effort to maintain patient confidentiality and the guidelines within the HIPAA regulations, please fill out this section in regards to having someone other than you obtain information regarding upcoming appointments and/or information from your medical record.

☐ I decline to give permission to a family member/friend.

☐ I give permission to the following family/friend:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Please do not share information about my child’s care between Blue Zone Health providers.

**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Why are you seeking care? Pain Wellness Nutrition/Lifestyle Other** | | |
| What is the area of complaint/concern? |  | |
| When did the symptoms start? |  | |
| Has your child experienced this before? |  | |
| Has school been missed due to this condition? | |  No  Yes  How Long? |
| Is this condition due to an automobile accident? | |  No  Yes |
| Has your child been seen by another provider or received treatment for this condition? | |  No  Yes  Whom? |
| Has there been any previous tests, x-rays, CT scans or MRI’s previously taken? | | No  Yes  What was done? |
| Has your child been checked by a doctor of chiropractic before? | |  No Yes  Whom? |
| Any developmental concerns? | |  |

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| **Medications/Allergies** | | | | | | | |
| Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements.   If NO current medications please check here | | | | | | | |
| Medication/Supplement | | Dose | | | | Frequency | |
| 1. | |  | | | |  | |
| 2. | |  | | | |  | |
| 3. | |  | | | |  | |
| Please list any known allergies your child may have.   If no known allergies, check here | | | | | | | |
| 1. | | | | 2. | | | |
| 3. | | | | 4. | | | |
| **Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.** | | | | | | | |
| **Cardiovascular** | **Digestive** | | | | **Endocrine** | | **Integumentary** |
| No issues | No issues | | | | No issues | | No issues |
| Heart Defect | Reflux/GERD | | | | Diabetic  Type I Type II | | Psoriasis |
| Excessive Bruising | Colic | | | | Swollen glands | | Eczema |
| Palpitations | Constipation | | | | Other | | Acne |
| Asthma | Diarrhea | | | | **Developmental** | | Rash |
| Persistent cough | Food Sensitivities | | | | Delayed Speech | | Birth marks |
| Mouth-breather | Poor Appetite | | | | Delayed gross motor skills | | Other |
| Congestion | Anorexia/ Bulimia | | | | Delayed fine motor skills | |
| Bronchitis/Pneumonia | Other | | | |  Delayed social skills | |
| **Immune** | **Constitutional** | | | | **Musculoskeletal** | | **Neurological** |
| No issues | Lethargic | | | | Joint/Bone pain | | Dizziness |
| Chronic colds | Difficulty sleeping/ Irregular sleep patterns | | | | Growing pains | | Balance/Coordination Issues |
| Laryngitis/Tonsilitis |
| Ear & Sinus Infections | Bed-wetting | | | | Headaches | | Epilepsy/Seizures |
| Low Energy | Pre-mature birth | | | | Developmental Delays | |  Visual/hearing issues |
|  UTI’s |
| Other | PTSD | | | |  Torticollis | | ADD/ADHD |
| Other | | | |  Scoliosis | | Autism Spectrum |
|  Abnormal Walk | | Focus/Memory Issues |
| TMJ/Jaw pain | | Speech Issues |
| Poor Posture | | Anxiety/Depression |
| Other | | Other |
| **Daily Habits** | | | | | | | |
| **How much exercise does your child get?** | | |  | | | | |
| **How much time does your child spend watching TV or a screen?** | | | About\_\_\_\_\_\_\_\_\_\_\_ hrs. per day | | | | |
| **What sports or activities does your child participate in?** | | | My child doesn’t engage in sports/activities  Yes, my child plays… | | | | |
| **What position does your child sleep in?** | | | Back Side Stomach | | | | |
| **How much sleep are they getting a day?** | | | \_\_\_\_\_\_\_\_\_\_\_ hrs. | | | | |
| **What is a typical breakfast for your child?** | | |  | | | | |
| **How would you rate their diet?** | | | Poor Fair Healthy Very Healthy | | | | |

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| **Please date/list reasons for any hospitalizations or surgical procedures.** | |
| **Date** | **Reason** |
|  |  |
|  |  |
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| **Please describe any other injuries/accidents not mentioned previously.** | |
| **Date** | **Injury** |
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| Are there any past or current medical conditions you have not told us about? | |
| **Family History**  Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.) | |
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| What makes your child happy? |

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| Is there anything additional we should know about your child? |

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**