EDEN
CHIROPRACTIC
rooted in health

1630 BUFORD HWY NE, STE 6, BUFORD, GA, 30518 | 770-945-0561

#_____

PEDIATRIC EVALUATION PAPERWORK

HELLO AND WELCOME!

Who may we thank for referring you / how did you hear about us? _____

Has your child received chiropractic care in the past? ▢ No ▢ Yes Where? _____

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age:_____
Preferred Name:_____ Gender: ▢Male ▢ Female
Email: _____
Street Address: _____ City/State/Zip:_____
Guardian 1: _____ Relationship : _____
Phone (cell/home): _____ Email: _____
Guardian 2: _____ Relationship: _____
Phone (cell/home):_____ Email: _____
Who is responsible for child's finances? Siblings (name(s) + age(s)): _____
▢ Guardian 1 ▢ Guardian 2 ▢ Both _____

PERSONAL HEALTH BACKGROUND

If your child is above the age of 5, please skip to Personal Health Background

Birth Height: ___ft ___in Birth Weight: ___lbs At How many weeks was your child born?____
▢ Doctor/ ▢ Midwife: _____ Delivery Method: ▢ Vaginal ▢ C-Section ▢ VBAC List any medications taken during pregnany: ▢N/A_____
List any complications, serious illness, or health emergency mother experienced during birth or pregnancy: ▢ N/A _____

PERSONAL HEALTH BACKGROUND

Current Weight:____lbs Height: ___ft ___in
Has your child received vaccines? ▢ No ▢ yes
yes ▢ on regular schedule ▢ delayed schedule
Is your child exposed to secondhand smoke?
▢ Never ▢ Past ▢ Occasionally ▢ Daily

Indicate if your child has experienced any of the *if* following:
▢ N/A ▢ Been unconscious due to illness of injury
▢ Serious illness, operation, or health emergency ▢ Motor vehicle accident ▢ Fractured a bone *Explain:*
_____

PRESENT ILLNESS

What is the **MAIN** reason you are seeking chiropractic care for your child?

PRIMARY PROBLEM/CONCERN: _____

Rate child's **CURRENT** pain/discomfort:___ /10 **WHEN** did the problem begin? _____
Did anything specific start or worsen this issue?
▢ No ▢ Yes If yes, explain:_____
Does the problem **RADIATE/TRAVEL/SPREAD**? ▢ No ▢ Yes Where?_____
HOW OFTEN does your child experience the problem?
☐ Constant ☐ Frequent ☐ Occasional ☐ Rare ☐ Daily ☐ Weekly ☐ Monthly ☐ AM / PM
WHEN is the problem at its worst? ▢ Morning ▢ Mid-day ▢ Evening ▢ Other _____
What **RELIEVES** the problem? _____
What makes the problem **WORSE**? _____

Are there any **SECONDARY** health concerns you would like to address?

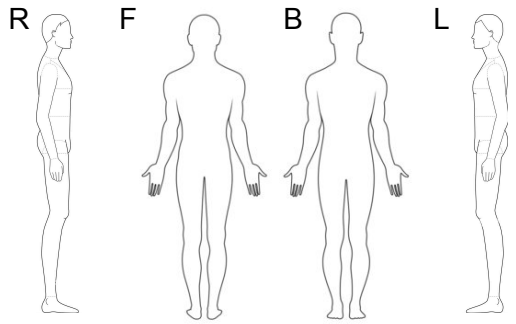
OTHER PROBLEM/CONCERN: _____

Rate your **CURRENT** pain/discomfort: ___/10 **WHEN** did the problem begin? _____
Did you do something/did something happen that caused/aggravated the problem?
▢ No ▢ Yes If yes, explain:_____
Does the problem **RADIATE** outward? ▢ No ▢ Yes If yes, where? _____
HOW OFTEN do you experience the problem?
▢ always ▢ often ▢ occasionally ▢ rarely ▢ monthly ▢ weekly ▢ daily (▢ AM / ▢ PM)
WHEN is the problem at its worst? ▢ Morning ▢ Mid-day ▢ Evening ▢ Other _____
What **RELIEVES** the problem? _____
What makes the problem **WORSE**? _____

PERSONAL INFORMATION

Have you experienced this (or a similar problem) before? ▢ Yes ▢ No
What treatment did you seek? ▢ N/A _____ How were your results? ▢ Good ▢ Poor
Help us identify past conditions or procedures that could be related to your *child's main issue:*
☐ N/A ☐ Surgeries ☐ Past injuries ☐ Childhood illness Explain: _____
Medications or supplements your child is currently taking:_____
_____
Have you *experienced or been diagnosed* with any of the following?
▢ N/A ▢ Pain that wakes you up at night ▢ night sweats ▢ stroke ▢ heart attack ▢ diabetes
Explain:_____

Directions: On the diagrams to the RIGHT,
CIRCLE the area(s) that to your pain/symptom(s):
How would you describe the problem(s)?
☐ Aching ☐ Tight/Stiff ☐ Sharp/Stabbing
☐ Burning ☐ Numbness ☐ Tingling
☐ Radiating ☐ Deep/Dull ☐ Throbbing
▢ Other: _____



_____ INITIALS

ACTIVITIES **OF DAILY LIVING**					
	CAN COMPLETE	CAN COMPLETE	CAN COMPLETE	**CANNOT** COMPLETE due to pain	
	Without Pain or difficulty	***WITH MINIMAL*** Pain or difficulty	***WITH SEVERE*** Pain or difficulty		N/A
Exercise	▢	▢	▢	▢	▢
Nursing/Latch	▢	▢	▢	▢	▢
Bathe/Shower	▢	▢	▢	▢	▢
Brush teeth	▢	▢	▢	▢	▢
Climbing Stairs	▢	▢	▢	▢	▢
Getting Dressed	▢	▢	▢	▢	▢
Household Chores	▢	▢	▢	▢	▢
Daily Physical Activity	▢	▢	▢	▢	▢
Standing	▢	▢	▢	▢	▢
Walking	▢	▢	▢	▢	▢
Sitting	▢	▢	▢	▢	▢
Kneeling/Crawling	▢	▢	▢	▢	▢
Lifting	▢	▢	▢	▢	▢
Reach Overhead	▢	▢	▢	▢	▢
Bend Forward	▢	▢	▢	▢	▢
Turn Left	▢	▢	▢	▢	▢
Turn Right	▢	▢	▢	▢	▢
Seated to Standing	▢	▢	▢	▢	▢
Sleep	▢	▢	▢	▢	▢
Carry bag/Purse	▢	▢	▢	▢	▢
Run/Hike	▢	▢	▢	▢	▢
Get In/Out of Car	▢	▢	▢	▢	▢
Drive	▢	▢	▢	▢	▢
Use Computer	▢	▢	▢	▢	▢
Focus/Concentrate	▢	▢	▢	▢	▢
Other: _____	▢	▢	▢	▢	▢

_____ INITIALS

CURRENT OR PAST HISTORY

CONDITION	CURRENT	PAST	NEVER	
Acid Reflux / Heartburn / GERD	▢	▢	▢	
ADHD/ADD	▢	▢	▢	
Allergies	▢	▢	▢	
Anxiety	▢	▢	▢	
Arthritis / Joint Pain	▢	▢	▢	
Asthma / Breathing Difficulties	▢	▢	▢	
Cancer	▢	▢	▢	
Carpal Tunnel Syndrome	▢	▢	▢	
Chest Pain	▢	▢	▢	
Concussion	▢	▢	▢	
Depression	▢	▢	▢	
Diabetes	▢	▢	▢	Type I / Type II
Disc Problems	▢	▢	▢	Where?
Ear Problems	▢	▢	▢	
Ehlers Danlos	▢	▢	▢	
Fibromyalgia	▢	▢	▢	
Headaches / Migraines	▢	▢	▢	
High / Low Blood Pressure	▢	▢	▢	
Infertility	▢	▢	▢	
Irritable Bowel Syndrome	▢	▢	▢	
Menstrual Dysfunction	▢	▢	▢	
Numbness/Tingling	▢	▢	▢	
Scoliosis	▢	▢	▢	
Sinus Problems	▢	▢	▢	
Swelling of Legs/Feet	▢	▢	▢	
Thyroid Dysfunction	▢	▢	▢	
TMJ/Jaw Pain	▢	▢	▢	
Tremors	▢	▢	▢	
*Organic/System Problems	▢	▢	▢	

<u>*Select all that apply:</u> ▢ Digestive ▢ Gallbladder ▢ Cardiac ▢ Liver ▢ Stomach ▢ Pancreas ▢ Reproductive ▢ Lung/Respiratory ▢ Urinary ▢ Kidney ▢ Prostate ▢ Vision ▢ Thyroid ▢ Skin▢ Sexual ▢ Other(s) _____

_____ INITIALS

NOTICE OF PRIVACY PRACTICES

This office is required by law to maintain the privacy and confidentiality of your **Personal Health Information (PHI)**.

We must also provide you with written notice regarding your rights to access your health information, as well as the circumstances under which we are permitted—by law or by office policy—to disclose information about you to a third party without your authorization.

Below is a brief summary of these permitted disclosures and your rights. A more detailed explanation is available upon request.

Please review this notice carefully, then sign and return it with your paperwork. If you would like to keep a copy for your records, please ask our front desk receptionist.

Permitted Disclosures

1. **Treatment Purposes** – Discussion with other health care providers involved in your care.
2. **Inadvertent Disclosures** – Our open treatment area allows for open discussion. If you prefer private communication, please let our staff know so we can accommodate you in a private consultation room.
3. **Payment Purposes** – To obtain payment from your insurance company or other payment sources.
4. **Emergencies** – To notify a family member in the event of a medical emergency.
5. **Public Health and Safety** – To prevent or lessen a serious or imminent threat to the health or safety of an individual or the public.
6. **Government or Law Enforcement** – To identify or locate a suspect, fugitive, material witness, or missing person.
7. **Military, National Security, or Government Benefits** – When required by law.
8. **Deceased Persons** – To assist coroners or medical examiners in the event of a patient's death.
9. **Telephone Calls, Emails, and Appointment Reminders** – We may contact you regarding missed appointments, office hour changes, or upcoming events.
10. **Change of Ownership** – In the event this practice is sold, the new owner(s) may have access to your PHI as part of the practice records.

Your Rights:

1. To receive an **accounting of disclosures**.
2. To receive a **paper copy** of the detailed Privacy Notice.
3. To request **mail delivery** to an alternate address.
4. To request **restrictions** on certain uses or disclosures of your PHI and to specify individuals with whom information may or may not be shared. While we are not required to agree, any approved restriction will remain in effect until you provide written notice to remove it.
5. To **inspect and obtain one copy** of your records at no charge, with at least 72 hours' notice.
6. To request **amendments** to your records. We are not required to agree to requested changes.
7. To obtain **one copy of your records at no charge** with timely notice (72 hours). Please note that X-rays are original medical records and cannot be released. If you wish to have copies made through an imaging center, we will assist you, but you will be responsible for the associated costs.

Complaints

If you wish to file a complaint regarding how this office handles your health information, please contact Kelly Stone, 770-945-0561. If unavailable, you may schedule an appointment with our receptionist to meet with within 72 hours (3 business days). If you are not satisfied with how your complaint is handled, you may submit a formal complaint to: U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Ave SW, Room 509F, HHH Building, Washington, DC 20201

Acknowledgment of Receipt

I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices for this office and understand my rights and the permitted disclosures of my health information.

Guardian Name (printed)**:** _____

Guardian Signature: _____

Date: _____

_____ INITIALS

CHIROPRACTIC CARE INFORMED CONSENT

I understand that chiropractic care, like all health care, carries some risk. Though rare, complications such as sprain/strain, disc irritation, minor fracture, or stroke (about 1 per 1–2 million adjustments) may occur.

My treatment goals and potential risks have been explained to me, and I consent to treatment by any method or technique the doctor deems necessary throughout my care.

Guardian Signature: _____ Date: _____

X-RAY CONSENT

X-rays may be recommended to help locate and evaluate spinal subluxations. The doctors at Eden Chiropractic do not diagnose or treat medical conditions. However, I understand that I will be informed if any abnormal findings are observed.

I have been advised of the potential risks associated with ionizing radiation and consent to any X-rays the doctor determines to be necessary for my child's care.

Do you authorize X-rays for your child if the doctor determines they are necessary?
☐ Yes ☐ No

Guardian Signature: _____ Date: _____

INFORMATION RELEASE AUTHORIZATION

I authorize Eden Chiropractic to release necessary information regarding my health condition to my insurance company, billing company, attorney, adjuster, or other healthcare providers involved in my care, as needed to process claims or coordinate treatment.

This authorization remains in effect until revoked by me in writing. A photocopy of this form is as valid as the original.

I confirm all information provided is true and accurate, and I authorize Eden Chiropractic to proceed with necessary chiropractic testing, diagnosis, analysis, and adjustments.

Guardian Signature: _____ Date: _____