YOUNG ADULT HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____
Last First

AGE: _____ **Grade In School:** _____ **Sex:** _____ **Home Phone:** (____)_____

Address: _____ **City/Town:** _____ **State:** _____ **Zip:** _____

Mother's Name: _____ **Phone:** (____)_____
Last First

Father's Name: _____ **Phone:** (____)_____
Last First

Referred by: _____

***HEALTH CONCERNS*:** Please list your / your child's top health concerns or complaints that you would like to address (in order of priority):

1) _____

2) _____

3) _____

Pregnancy History (Mother)
(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ C-section
- ❑ The child was a "blue baby"
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia
- ❑ The child was premature (2+ weeks)

Comments: _____

_____

_____

Newborn History
Did the child experience any of the following as a newborn:

- ❑ Difficulty latching/sucking
- ❑ Breast fed – length of time _____
- ❑ Colic
- ❑ Formula fed
- ❑ Bottle fed

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems
- ❑ Adverse reaction to any vaccinations (even if mild)

If yes, please explain: _____

_____

Developmental History
Does or did your child have any of the following:

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination
- ❑ Did not crawl on all fours
- ❑ Appeared clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____

_____

Neurological/Other
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

GENERAL INFORMATION:

Height:_____ Weight:_____ Recent Weight Loss ☐ / Gain ☐ Amount: _____ lbs

Reason / method for weight loss / gain: _____ Number of Bowel Movements per day _____

Difficulty falling asleep? ☐ Y ☐ N Difficulty staying asleep? ☐ Y ☐ N Tired after full night's sleep? ☐ Y ☐ N

Lightheaded / irritable when hungry? ☐ Y ☐ N Crave sugar / salt? ☐ Y ☐ N Fatigue after meals? ☐ Y ☐ N

Need coffee/sweets 3-5pm? ☐ Y ☐ N Does your child eat Breakfast? ☐ Y ☐ N Or eat snacks? ☐ Y ☐ N

Usual Breakfast time? _____ Usual breakfast foods:_____

Usual Lunch time? _____ Usual lunch foods:_____

Usual Dinner time? _____ Usual dinner foods:_____

Are there usual Snack times? _____ Usual snacks:_____

List the three healthiest foods eaten during the average week: _____ _____ _____

List the three worst foods eaten during the average week: _____ _____ _____

Are there any dietary restrictions? ☐ Y ☐ N Please explain: (vegetarian, gluten / dairy intolerance, Kosher etc.)_____

_____

HEALTH & FAMILY HISTORY:

Mark an X for any conditions that **you**, or any of **your family members** have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Anemia						
Cancer						
Cold sores						
Deep vein thrombosis						
Depression/Anxiety						
Diabetes						
Eczema/Psoriasis						
Epilepsy						
Goiter						
Gout						
Heart disease						
Hepatitis A/B/C						
Herpes						
High Blood Pressure						
HIV/AIDS						
Pleurisy						
Pneumonia						
Stroke						
Tumor(s)						
Ulcer(s)						
Other:						

NATIONALITY: Some health issues can be related to our familial nationality or heritage. Please list your family heritage below:

Mother's Family _____ Father's Family_____

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

☐ **Food:** ☐Gluten ☐Dairy ☐Soy ☐Nuts ☐Other _____

☐ **Medications:** _____

☐ **Seasonal/Latex/Other:** _____

ACCIDENTS: Has your child been involved in any of the following types of accidents? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse ☐ Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Has your child ever injured any of the following regions? (check all that apply)

☐ Head ☐ Neck ☐ Rib/Chest ☐ Back ☐ Pelvis/Hip ☐ Arm/Hand ☐ Leg/Foot

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

SERIOUS ILLNESSES / HOSPITALIZATIONS / SURGERIES: Please detail hospitalizations / serious illnesses / surgeries

Year ***(approximate)***	**Reason**	**Outcome**

MEDICATIONS: Please list all medications your child is currently or has taken (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Prescribed By?**

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional Supplements your child is currently or has taken

Supplement	**Brand** & **Amount Consumed**	**Date Started**	**Prescribed by?** *(if applicable)*

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times your child has taken antibiotics for illnesses, ear infections, skin disorders (including acne), dental procedures, surgery etc._____ Has your child ever been on a long term antibiotic (1 month or more) or Intravenous (IV) ? ☐Y ☐N Has your child ever taken probiotics? ☐Y ☐N

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Soda/Diet Soda	☐	☐	☐	☐	_____
Coffee/Caffeine	☐	☐	☐	☐	_____
Alcohol	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Rec. Drugs	☐	☐	☐	☐	_____

If your child no longer consumse the above, please note length of consumption and date stopped.

	5-7x/wk	3-5x/wk	1-3x/wk	None	
Exercise/Sports	☐	☐	☐	☐	
	8+ hrs	**7-8 hrs**	**6-7 hrs**	**5-6 hrs**	**<5 hrs**
Sleep	☐	☐	☐	☐	☐
	5+	**4**	**3**	**2**	**1**
Meals / day	☐	☐	☐	☐	☐
	8+ cups	**4-7 cups**	**2-4 cups**	**<8 oz**	
Water / day	☐	☐	☐	☐	

How many times a week does your child eat out?: _____

How many times a week does your child eat fish? _____

How many times a week does your child eat raw nuts or seeds?: _____

Has your child lived or traveled outside of the United States? ☐ Y ☐ N If yes: Where _____

_____

Do you / your child have any pets or farm animals? ☐ Y ☐ N If yes: _____

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

If you have any concerns or questions you would like to note here, or issues you think might be related to your child's condition please do not hesitate to discuss any matter with Dr. Slavin at any time.

_____

_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Jacqui Slavin, D.C. of Functional Wellness, LLC to examine, evaluate and treat _____ under the scope of Chiropractic Care in the

Name of Minor Patient

State of Colorado.

_____ _____

Signature and relation of person completing this form **Date**

Functional Wellness LLC
720 S. Colorado Blvd, Denver, CO 80246
PO BOX 85, Edwards, CO 81632
Phone: 970-376-7779 ~ Fax: 888-376-6372

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY

EFFECTIVE: SEPTEMBER 22, 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.
Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer:	Jacqui Slavin
Address:	720 S. Colorado Blvd, Denver, CO 80246 ~ PO BOX 85, Edwards, CO 81632
Telephone:	970-376-7779
Fax:	888-376-6372
Email:	functionalwellness@live.com

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720 S. Colorado Blvd, Denver, CO 80246
PO BOX 85, Edwards, CO 81632
Phone: 970-376-7779 ~ Fax: 888-376-6372

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Functional Wellness LLC's Notice of Privacy Practices, which has an effective date of September 22, 2013, and which describes how my health information may be used and disclosed.

At this time Functional Wellness, LLC does NOT share ***Private Health Information for Marketing Purposes****, nor does it engage in* ***Fundraising Activities****. Therefore the* Authorizations for Use of Private Health Information for Marketing Purposes *and the* Opt Out for Fundraising Activities *release documents are not relevant at this time. Should business practices change, Functional Wellness, LLC will notify me as required.*

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)

Financial Policy

Due to the specialty and nature of our services at Functional Wellness, LLC patients are responsible for payment at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

We make every effort to work with your general practitioner for routine lab work, and provide the most competitive options for specialty testing, especially those that accept most insurance plans.

Payments made for services rendered at Functional Wellness, LLC can also be applied toward your annual deductible, and should be eligible expenditures for Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). We are happy to provide you with standard documentation and coding required by your provider / coverage entity. (Detailed documentation may be subject to standard hourly rate.)

We encourage patients to understand your individual health insurance policy and to contact your provider for clarification of benefits and reimbursement procedures prior to services being rendered. Many chiropractic procedures, as well as nutritional consultations may be covered by traditional policies, however this differs greatly by provider and network.

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call our office prior to the time of your appointment to make appropriate arrangements. If you arrive more than 10 minutes late to your scheduled appointment, you may be asked to reschedule.

Fee Schedule	
Cancellation, Missed Appointments and Late Arrivals	If you need to cancel an appointment, we kindly request that you allow at least 24-hours notice so that your appointment may be given to another patient who may be in need of urgent care. If we do not receive 24-hours notice there will be a $150.00 cancellation fee billed for an average length appointment. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
Returned Check Fee	There will be a $35 charge for all returned checks.
Collection Fee	If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the child's medical costs, it is the authorizing parent's responsibility to collect from the other parent.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient