Andrew Dodge, DC
1600 N. Coalter St., Ste. 302
Staunton, VA 24401
www.ValleyFamilyWellness.com
Phone: 540-885-1735
Fax: 540-885-1736

Patient Introduction

Personal History:

Your Name: ____
First Middle Last

Your Address:

____

____

____

Telephone Home: __________________ Bus: ___________________ Cell: ____________________

Email: ____

I would like to receive Valley Family Wellness and Chiropractic Newsletters: Yes:_____ No:____

Birth Date: ____________________ Age: _________________ SSN: _______________________

Marital Status: _________________ Spouse's Name: __________________ No. Children_________

Occupation: ______________________________ Employer: ________________________________

Previous Chiropractor: _________________________________ City: ___________________________

Last visit to this Chiropractor: ____

Reason for leaving:

____

____

Present MD: ____________________________________ City: ________________________________

Referred to our Office by:

____

Signature: ____ Date: ____________________________

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Initial Child & Adolescent Questionnaire

Your Name: ______________________________ Your Mom: ______________________________

Your Dad: ______________________________

Mainly for Moms:

1. Tell us about your pregnancy

Did you carry to full term? ____

Any major stress during pregnancy? ____

Describe any complications and when they occurred: ________________________________

____

2. Tell us about your delivery and birth of this child:

Midwife? __________ Obstetrician?_________ Birth Center? ____ Hospital?___ Home?___

Did you have a C-section? _______ Were forceps used? _______ Vacuum Extraction?______

Were you induced? ______ (___Pitocin ___ Cervadil) Did you have an Epidural? _______

Was it a difficult birth? ______ Length of labor? _______ Was excessive force used?_____

Did you tear? ______ Did you have an episiotomy? _____ Baby's position abnormal? ____

What was the baby's APGAR score at birth? _________ At 5 minutes? _________________

3. Tell us more:

Did you breastfeed, and how soon after birth? ________________ Until what age?________

What formula after? __________________ What food was introduced first?_______________

Did you consume alcohol during pregnancy? ____________ How much?_________________

Did you smoke? ______________ How much? _________________ How long? _____________

Did you take any medication during your pregnancy? _________________________________

For what? ___________________________________ What type? ____________________________

Any exposures to ultrasound? ________ How many?_________ Amniocentesis? _________

4. As a baby / toddler (birth to 4 years), did any of the following occur?

_______ Fall from a changing table
_______ Tumble down stairs
_______ Fall out of crib
_______ Involved in car accident
_______ Fall off playground equipment
_______ Play in a Jolly Jumper
_______ Frequent ear infections
_______ Tonsillitis
_______ Reaction to vaccination
_______ Nosebleeds
_______ Problems feeding
_______ Frequent crying spells
_______ Frequent fevers
_______ Frequent bouts of diarrhea
_______ Constipation
_______ Sleeping problems
_______ Frequent colds
_______ Colic
_______ Did not gain weight
_______ Allergies
_______ Skin problems
_______ Other ____________________

Please explain the above: ____

____

____

5. As a young child (5-12 years), did any of the following occur?

_______ Fall from a tree
_______ Fall off a bicycle
_______ Fall off playground equipment
_______ Sports accident
_______ Car accident
_______ Stomach Pains
_______ Scoliosis
_______ Bed wetting
_______ Hyperactivity/Autism
_______ Learning difficulties
_______ Asthma
_______ Allergies
_______ Leg/knee pains
_______ Other____________________

Please explain the above: ____

____

____

6. Tell us about any vaccinations your child has had:______________________________________

____

____

Any reactions to any of these? ____

____

Were you told that you had a choice in vaccinating your child? _____ Yes _____ No

Would you like information on the other side of the issue? _____ Yes _____ No

7. As a child or adolescent, has your child experienced any of the following?

_____ Headaches _____ Numbness in arms/hands _____ Foot/ankle/knee pains

_____ Dizziness _____ Arm/wrist pains _____ Tingling in arms/legs

_____ Ringing in ears _____ Sleeping problems _____ Neck/back pains

_____ Asthma _____ Allergies _____ Shoulder pains

_____ Hyperactivity _____ Stomach problems _____Growing pains

_____ Fatigue _____ Weight gain/loss _____ Other ________________

Please explain the above: ____

____

____

8. Which of the problems you have checked off is the worst? ________________

____

Is this problem: Constant _____ Intermittent _____ Occasional _____ Cyclic _____

9. How long has it persisted? ____

10. When it is at its worst, how does it make your child feel? _________________

11. What have you done about it that has NOT worked? _____________________

____

____

12. What makes it worse? ____

13. What effect does this problem have on your child's body functions? _________

____

____

14. Describe any hospital stays: ____

____

15. Approximately how many times have antibiotics been prescribed and for what conditions? ____

____

16. List any medications your child is currently taking: ______________________________

____

17. To summarize, what is your purpose for this appointment? ____________________

____

18. Is there anything else you feel we should know? ___________________________

____

____

____

Signature of parent or guardian: ______________________________ Date: ______________

THANK YOU !

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Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that is responsible to let you know:

a. Risk of stroke is reported to be 1 in 5-8 million or so…and the cause has yet to be determined.
b. While extremely rare, there have been reports of ligament sprains and even rib fractures.
c. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.

Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor and extend this consent to include all doctors of Valley Family Wellness and Chiropractic. This consent applies to all present and future care for my family and me.

Your Name ____ Date _________________

Your Signature ____

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Privacy Notice and Agreement

This form is to inform you, the patient, of some of our programs and traditions at Valley Family Wellness and Chiropractic. These programs and traditions include the use of your personal information, and we provide this form so that you are given the chance to object to any of these programs or traditions, if you so desire.

______ I give Valley Family Wellness and Chiropractic permission to call me by name in the office and on the phone

______ I give Valley Family Wellness and Chiropractic permission to take my child's picture with his/her chiropractor and to post it on the "Kid's Board" in the office with their first name, last initial, and date.

______ I give Valley Family Wellness and Chiropractic permission to send me a birthday card on my birthday or to call me on my birthday.

______ I give Valley Family Wellness and Chiropractic permission to call and remind me of upcoming appointments or to reschedule my appointments.

______ I give Valley Family Wellness and Chiropractic permission to mail things such as new patient kits, cards for various occasions, special promotions, etc.

_____ If I provide my email address to Valley Family Wellness and Chiropractic, I give them permission to email me such things as newsletters, talk dates, clinic closings, research, etc.

_____ If I fill out a testimonial form or write a letter of that nature, I give Valley Family Wellness and Chiropractic permission to use that information in whatever way they see fit (as an example at talks, in notebooks in the waiting room, on their website.)

I have read and fully understand the above information on the programs and traditions of Valley Family Wellness and Chiropractic. I have given my permission and/or made my objections clear.

Patient's Name (print):_________________________________ Date:___________________________

Patient's /Guardian's Signature:____

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Notice of Privacy Practice

We are required by law** to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Chiropractic Practice of Dr. Andrew Dodge has adopted the following privacy policies.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of test procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used as necessary to support the day-to-day activities and management of our office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health rendering. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of the information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information may be used by our staff to notify you of appointment reminders.

Information about treatments. Your health information may be used to send you information on treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. the right to request restrictions on the use and disclosure of your Protected Health Information;
2. the right to receive confidential communications concerning your medical condition and treatment;
3. the right to inspect and copy your Protected Health Information;
4. the right to amend or submit corrections to your Protected Health Information;
5. the right to receive an accounting of how and to whom your Protected Health Information has been disclosed;
6. the right to receive a printed copy of this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all Protected Health Information we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or your chiropractor; be aware that we reserve the right to charge for copies of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to your chiropractor outlining your concerns at:

Valley Family Wellness and Chiropractic
1600 N. Coalter Street
Suite 302
Staunton, VA 24401

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concerns to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is Dr. Andrew Dodge at the address listed above.

**HIPAA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law, 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality, and security of health care information. It impacts all areas of health care industry.

______________________________ ________________________

Signature Date