



# 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 pregnancy:  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 Indicate if your child has experienced any of the

Has your child received vaccines?  No  yes if following:

yes  on regular schedule  delayed schedule  N/A  Been unconscious due to illness of injury

Is your child exposed to secondhand smoke?  Serious illness, operation, or health emergency

Never  Past  Occasionally  Daily Motor vehicle accident  Fractured a bone Explain: \_\_\_\_\_

\_\_\_\_\_ INITIALS

## 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):

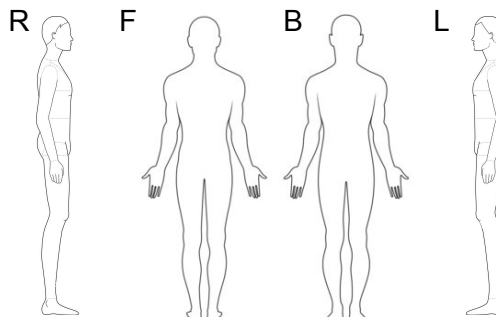
How would you describe the problem(s)?

Aching  Tight/Stiff  Sharp/Stabbing

Burning  Numbness  Tingling

Radiating  Deep/Dull  Throbbing

Other: \_\_\_\_\_



\_\_\_\_\_ INITIALS

**ACTIVITIES OF DAILY LIVING**

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

\_\_\_\_\_ INITIALS

**CURRENT OR PAST HISTORY**

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

**\*Select all that apply:**  Digestive  Gallbladder  Cardiac  Liver  Stomach  
 Pancreas  Reproductive  Lung/Respiratory  Urinary  Kidney  Prostate  
 Vision  Thyroid  Skin  Sexual  Other(s) \_\_\_\_\_

\_\_\_\_\_ INITIALS

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## NOTICE OF PRIVACY PRACTICES

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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

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### CHIROPRACTIC CARE INFORMED CONSENT

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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:** \_\_\_\_\_

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### X-RAY CONSENT

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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:** \_\_\_\_\_

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### INFORMATION RELEASE AUTHORIZATION

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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:** \_\_\_\_\_

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