



MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.  
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

<b>Welcome to Our Blue Zone Health Family!</b>		
<b>Your child's health history is important to us. Please fill out this form COMPLETELY.</b>		
<b>Today's Date:</b>		
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:
Home #:	Cell #:	Work #:
Would you like us to send you a text message for your future appointment reminders?		
<input type="checkbox"/> <b>Yes, Text Please!</b> <input type="checkbox"/> <b>No Thank you, No Reminder needed.</b>		
Email:		
Date of Birth:        /        /	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other _____
Emergency Contact Name:		Relationship:
Emergency Contact Phone #: (     )		Secondary #: (     )
Primary Care Provider:		Phone: (     )
Primary Care Provider Address:		
Who may we thank for referring you?		

<b>What school/daycare does the patient attend:</b>
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<b>If you know your child's approximate height and weight please specify here</b>	Height: ____' ____"	Weight: _____lbs
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<b>Birth History</b>			
<input type="checkbox"/> <b>Vaginal</b>	<input type="checkbox"/> <b>C-Section</b>	Weeks gestation:	Birth Weight:
<b>Any concerns at birth or shortly after?:</b>			



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### **Consent to Treat and Bill**

By signing below, I understand that I hereby authorize Blue Zone Health (hereafter “BZH”) 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 BZH. I also authorize BZH 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 BZH 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 give permission to the following family/friend:

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

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

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



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<b>Why are you seeking care?</b> <input type="checkbox"/> Pain <input type="checkbox"/> Wellness <input type="checkbox"/> Nutrition/Lifestyle <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes How Long?
Is this condition due to an automobile accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has your child been seen by another provider or received treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	<input type="checkbox"/> No <input type="checkbox"/> Yes What was done?
Has your child been checked by a doctor of chiropractic before?	<input type="checkbox"/> No <input type="checkbox"/> Yes Whom?
Any developmental concerns?	

<b>Medications/Allergies</b>		
Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. <input type="checkbox"/> If NO current medications please check here		
Medication/Supplement	Dose	Frequency
1.		
2.		
3.		
Please list any known allergies your child may have. <input type="checkbox"/> If no known allergies, check here		
1.	2.	
3.	4.	



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<b>Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.</b>			
<b>Cardiovascular</b>	<b>Digestive</b>	<b>Endocrine</b>	<b>Integumentary</b>
<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	<input type="checkbox"/> No issues
<input type="checkbox"/> Heart Defect	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Diabetic <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Excessive Bruising	<input type="checkbox"/> Colic	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Eczema
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other	<input type="checkbox"/> Acne
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diarrhea	<b>Developmental</b>	<input type="checkbox"/> Rash
<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Delayed Speech	<input type="checkbox"/> Birth marks
<input type="checkbox"/> Mouth-breather	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Delayed gross motor skills	<input type="checkbox"/> Other
<input type="checkbox"/> Congestion	<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Delayed fine motor skills	
<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Other	<input type="checkbox"/> Delayed social skills	
<b>Immune</b>	<b>Constitutional</b>	<b>Musculoskeletal</b>	<b>Neurological</b>
<input type="checkbox"/> No issues	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Joint/Bone pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Chronic colds	<input type="checkbox"/> Difficulty sleeping/Irregular sleep patterns	<input type="checkbox"/> Growing pains	<input type="checkbox"/> Balance/Coordination Issues
<input type="checkbox"/> Laryngitis/Tonsilitis			
<input type="checkbox"/> Ear & Sinus Infections	<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Pre-mature birth	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Visual/hearing issues
<input type="checkbox"/> UTI's			
<input type="checkbox"/> Other	<input type="checkbox"/> PTSD	<input type="checkbox"/> Torticollis	<input type="checkbox"/> ADD/ADHD
	<input type="checkbox"/> Other	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Autism Spectrum
		<input type="checkbox"/> Abnormal Walk	<input type="checkbox"/> Focus/Memory Issues
		<input type="checkbox"/> TMJ/Jaw pain	<input type="checkbox"/> Speech Issues
		<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Anxiety/Depression
	<input type="checkbox"/> Other	<input type="checkbox"/> Other	



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<b>Daily Habits</b>	
<b>How much exercise does your child get?</b>	
<b>How much time does your child spend watching TV or a screen?</b>	About _____ hrs. per day
<b>What sports or activities does your child participate in?</b>	<input type="checkbox"/> My child doesn't engage in sports/activities <input type="checkbox"/> Yes, my child plays...
<b>What position does your child sleep in?</b>	<input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach
<b>How much sleep are they getting a day?</b>	_____ hrs.
<b>What is a typical breakfast for your child?</b>	
<b>How would you rate their diet?</b>	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Healthy <input type="checkbox"/> Very Healthy

<b>Please date/list reasons for any hospitalizations or surgical procedures.</b>	
Date	Reason
<b>Please describe any other injuries/accidents not mentioned previously.</b>	
Date	Injury

<p>Are there any past or current medical conditions you have not told us about?</p>
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**Family History**

Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)


Is there anything additional we should know about your child?

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