SCHARENBERG CHIROPRACTIC OFFICE
PEDIATRIC HEALTH HISTORY

Patient Name_____Nickname_____Date_____
SS# _____ Birth date_____ Sex M F Name of Parents/Guardians_____
Parents Birth Date_____Address_____
City_____ State_____ Zip_____ Home Phone_____ Parent's Work Phone_____
Cell Phone_____ Email Address_____ Referred by_____ _____

CONSULTATION

Reason for seeking chiropractic care:_____
When did the problem begin?_____
Is this problem [ ] Occasional [ ] Frequent [ ] Constant [ ] Intermittent [ ] Other
_____
Does the problem radiate? No Yes If yes , where? _____
What makes it worse?_____
What makes it better?_____
Is the problem worse during a certain time of the day? No Yes If Yes, when?_____
Does it interfere with the child's [ ] Sleep [ ] Eating [ ] Daily routine? Is this becoming worse? No Yes
If yes, how?
_____ ___
Other professionals seen for this condition?_____
Results with treatment?_____

PRENATAL HISTORY

Name of Obstetrician/Midwife_____
Complications during pregnancy: No Yes List:_____
Ultrasounds during pregnancy: No Yes How many:_____
Location of Birth: [ ] Hospital [ ] Birthing Center [ ] Home
Birth Intervention: [ ] Forceps [ ] Vacuum [ ] Caesarian: Planned or Emergency
Complications during delivery: No Yes _____
Medications during pregnancy: No Yes List:_____
Medications during delivery: No Yes List:_____
Cigarette/Alcohol use during pregnancy: No Yes
Was the infant alert and responsive within 12 hours of delivery? No Yes
If No, Please explain
_____ _____
Birth Weight_____ Birth Length_____ APGAR Scores_____
Genetic disorders or disabilities?_____
Breast Fed: No Yes How Long?_____ Formula Fed: No Yes How long?_____
Solids at _____months Cow's Milk at _____months Food /juice allergies or intolerances No Yes
Anything else that needs to be noted:_____
At what age did the child: Respond to sound_____ Follow an object _____ Hold head up_____
Vocalize_____ Sit Alone_____ Crawl _____ Walk_____ Sleep through the night_____

Patient Name_____ DOB_____

Medication History

Previous Chiropractor:_____ Date of last visit & Reason_____

_____

Name of Pediatrician:_____ Date of last visit & Reason _____

_____

Are you satisfied with the care your child received there? Yes No

Immunization History: _____

Reactions:_____

Check all drugs your child is taking including prescription and non-prescription drugs

[ ] Asthma medication [ ] Tylenol [ ] Advil/Ibuprofen [ ] Cold tablets [ ] Allergy Med

[ ] ADHD Med [ ] Painkillers [ ] Anti-depressants [ ] Other_____ _____

Does your child take any Vitamins or Herbs? No Yes _____

Number of antibiotics your child has taken: Past 6 months_____ Total during his/her lifetime_____

Falls & Injuries

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life(i.e. a bed, changing table, down stairs, etc.).

Is this the case with your child? No Yes

When was your child's most recent fall?_____ What happened? _____

_____

Which of the following sports have your child been involved in?

[ ] Football [ ] Basketball [ ] Soccer [ ] Gymnastics/Cheerleading [ ] Martial Arts

[ ] Running [ ] Horseback riding [ ]Other: _____

Has your child ever broken a bone if so , which one? _____

Has your child ever been involved in an auto accident? No Yes Was there impact? No Yes

Were there injuries? No Yes (Dates/any treatment) _____

Has your child ever been seen on an emergency basis? No Yes (please list all) _____

_____

Other traumas not described above? No Yes _____

Prior surgery: No Yes If yes, Type and Date :_____Menses: No Yes Age:_____

Childhood Diseases & Illness

[ ] Acid Reflux [ ] ADD/ADHD [ ] Allergies [ ] Anemia

[ ] Arthritis [ ] Asthma [ ] Autism [ ] Backaches

[ ] Bed Wetting [ ] Behavioral Problems [ ] Blood Disorders [ ] Broken Bones

[ ] Bronchitis [ ] Car Accident [ ] Chicken Pox [ ] Chronic Colds

[ ] Chronic Ear Aches [ ] Colic [ ] Constipation [ ] Convulsions

[ ] Depression [ ] Diabetes [ ] Diarrhea [ ] Digestive Problems

[ ] Dizziness [ ] Ear Infections [ ] Epilepsy [ ] Fainting

[ ] Fatigue [ ] Growing Pains [ ] Headaches [ ] Heart Trouble

[ ] Hernias [ ] Hyperactivity [ ] Hypertension [ ] Jaundice

[ ] Loss of Balance [ ] Loss of Smell [ ] Mumps [ ]Neck Pain

[ ] Poor Appetite [ ] Poor Coordination [ ] Recurring Fevers [ ] Rubella

[ ] Scoliosis [ ] Seizures [ ] Shortness of breath [ ] Sinus

[ ] Sore Throats [ ] Stomach Aches [ ] Temper Tantrums [ ] Urinary Problems

[ ] Walking problems [ ] Whooping Cough [ ] Other :_____

Patient Name_____ DOB_____

Authorization to Treat a Minor

I, _____, Parent of Legal Guardian of _____
YOUR NAME (PRINT) CHILD'S NAME

Hereby authorize Dr. Dennis Scharenberg, D.C. and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/ former spouse or parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent/Guardian_____ Date_____

Scharenberg Chiropractic
421 N Webb Wichita, KS 67206

Patient Name_____DOB:_____ Date:_____

What brings you in today?

When symptoms started?

Did your baby see ***another doctor*** for this condition? Yes No Name_____

What did he/she do?

Did it help?

Does your baby ***scream and cry*** continuously?

When crying does your baby ***pull their legs up*** to their chest?

Does he/she ***sleep*** for short periods of time?

Would baby ***sleep on his/her back***?

Is he/she ***constipated***?

Does your baby have a ***hard*** and ***distended*** belly?

Does your baby ***grunt*** and **fuss** a lot?

Does your baby ***spit up***?

How often are his/her ***bowel movements***?

Has the baby had any ***vaccinations***?

Is your baby taking any ***medications***?

Is there any ***other information*** that you would like to share with the Doctor?

Dennis R. Scharenberg D.C.

SCHARENBERG CHIROPRACTIC

AUTHORIZATION TO TREAT & CARE

I, _____
YOUR NAME (PRINT)
Hereby authorize Dennis R. Scharenberg, D.C. and his staff to administer chiropractic care as they deem necessary. As of this date, I have the legal right to select and authorize health care services. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature _____Date_____

Dennis R. Scharenberg D.C.

SCHARENBERG CHIROPRACTIC
AUTHORIZATION FOR USE OF PICTURE/VIDEO
FOR EDUCATION

Please sign the following statement releasing permission to use your picture and/or video for use in our education of Chiropractic patients.

I _____, authorize Dr. Scharenberg's office to use my child's picture and/or video on the internet for training, education and testimonials relating to colic treatments.

I further agree not to disclose any procedures learned or taught with anyone outside my immediate family without written consent from Dennis R. Scharenberg D.C.

Date : _____

Signature: _____

SCHARENBERG CHIROPRACTIC

OUTPATIENT CLINIC FINANCIAL POLICY

1) We accept Cash, Checks, Visa, MasterCard, Discover Card and Care Credit.

2) All cash account payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.

3) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.

4) As a courtesy, we will bill your insurance company for you.

5) If you have a credit balance, we will reimburse you after all charges have been cleared.

6) All supplements/vitamins, supports, foot orthotics and other supplies are generally not covered by insurance companies and **must** be paid for at the time they are received.

7) As a courtesy, we will bill your insurance company for lab work.

8) You are responsible for timely payment of any account balances.

Workers Compensation Claims

9) All workers compensation cases require that a claim number be provided at the time of the first visit. The claim number can be obtained from the patient's employer. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

10) Personal injury and auto accident cases will be billed to your home or auto insurance company. When you inform your agent of your incident, you will be given a claim number which you must provide to us at your first visit.

11) Keep in mind we do not do third party billings to other insurance companies.

12) If you choose not to file a claim with your auto insurance company, or are uninsured, you account will be treated as a cash account, and all fees will be due at the time of service.

Colic Patients

13) Colic treatment is a *series* of treatments. Payment is expected at the first visit unless other arrangements are made in advance.

I have read, understand and agree with the above financial policy.

_____ _____

Patient/Guardian Signature Date

Dennis R. Scharenberg D.C.

Scharenberg Chiropractic

NOTICE OF PRIVACY PRACTICES

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

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 14, 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make prior to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS : You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal

relatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with you payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to advert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exception. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you the cost of copying, including supplies and labor, for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed you health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14,

2003. If you are request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENT TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You may also submit a written complain to us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to :

Contact Person :	Phyllis Scharenberg
Telephone:	316-945-0075
Fax:	316-945-0100
E-mail:	pscharenberg50@earthlink.net
Address:	421 N Webb
	Wichita, KS 67206

SCHARENBERG CHIROPRACTIC
ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ , [patient's name] acknowledge that I have received, reviewed, and understand and agree to the Notice of Privacy Practices of Scharenberg Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____
Date Signature

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of our efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons(check all that apply):

_____ Patient Unavailable
_____ Patient Physically Unable
_____ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner(check all that apply):

_____ Personally _____Mail _____ Phone follow-up _____ Other:_____

_____ _____
Date Signature

_____
Print Name of Physician

Scharenberg Chiropractic
Name of Practice

Dennis R. Scharenberg D.C.

A FREINDLY REMINDER

In order to decrease treatment time and leave with a happier baby, please bring:

1. A 5 oz. bottle of breast milk or formula

2. A pacifier

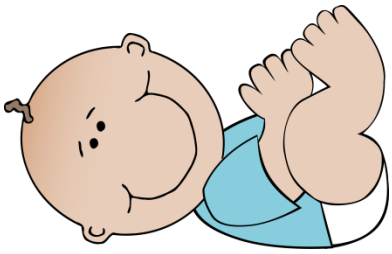
3. A blanket

4. Your regular diaper bag contents: diaper, clothing, etc.

5. Your food log completed for the previous meals if your are breast feeding.

We appreciate you and your baby and

want to make this experience the best it can be!



Dennis R. Scharenberg D.C.

DAILY FOOD AND BEVERAGE LOG

Please fill this in daily (including the days that you don't come in for treatment)
and bring it with you to EACH treatment. Please include any beverages!

Week 1:

Day 1 Breakfast:

Lunch:

Dinner:

Snacks:

Day 2 Breakfast:

Lunch:

Dinner:

Snacks:

Day 3 Breakfast:

Lunch:

Dinner:

Snacks:

Day 4 Breakfast:

Lunch:

Dinner:

Snacks

Day 5 Breakfast:

Lunch:

Dinner:

Snacks:

Dennis R. Scharenberg D.C.

Day 6 Breakfast:

Lunch:

Dinner:

Snacks:

Day 7 Breakfast:

Lunch:

Dinner:

Snacks:

Week 2:

Day 1 Breakfast:

Lunch:

Dinner:

Snacks:

Day 2 Breakfast:

Lunch:

Dinner:

Snacks:

Day 3 Breakfast:

Lunch:

Dinner:

Snacks:

Day 4 Breakfast:

Lunch:

Dinner:

Snacks:

Day 5 Breakfast:

Lunch:

Dinner:

Snacks:

Day 6 Breakfast:

Lunch:

Dinner:

Snacks:

Day 7 Breakfast:

Lunch:

Dinner:

Snacks:

Scharenberg Chiropractic
Colic Baby Intake Form

- **Name:**_____ **Date:**_____
- **Age NOW:** _____ **DOB**_____ **Sex: Male or Female**
- **Age Symptoms started:** _____

- **Feeding Method: Breast or Formula**
  - **Diet**

- **Methods for relief used:**
  - **Saw other doctor** _____
  - **Gas drops**
  - **Prescriptions**
  - **Formula change**

- **Symptoms**
  - **Arching back**
  - **Crying a lot**
  - **Won't sleep on back**
  - **Fussiness**
  - **Flailing arms and/or legs**
  - **Vomiting/spitting up**
  - **Grunting**
  - **Only sleeps for short periods**
  - **Eats constantly**
  - **Eats in short periods**
  - **Constipation / decreased bowel movements**
  - **Hard and distended belly**
  - **Pain when passing gas / having bowel movements**
  - **Continually wanting to suck**

Referred By: _____

Pediatrician: _____

Dad: _____

Mom: _____

Dennis R. Scharenberg D.C.

In Town Infant Colic Paitents

Here at Scharenberg Chiropractic we are informing you of our local infant colic patient policy. Our scheduling consits of seeing the patients' at a minimum of 10 consecutive visits, more if needed. The patients' guardians and the patient(s) progression with treatment is what ultimately decides whether that goes over 10. The Doctor will not release the patient until the patient's guardian(s) feel the patient(s) is completely symptom free.

Out of Town Infant Colic Paitents

Here at Scharenberg Chiropractic we are informing you of our out of town infant colic patient policy. We will schedule you twice a day in a five day work week to meet our minimum of 10 visits. If the patient(s) needs additional visits then we will schedule them. We will see the patient once in the morning and once in the afternoon. We space out the two visits with about 3 hour's difference to allow the first treatment to work and allow progress. There will be no additional charges for any infant colic patient(s) who are seen over 10 visits.

Our Office Charges for Infant Colic

Our office charges a one time flat fee of $600 for our infant colic patients. Payment is due after the first intial treatment unless payment aragngments have been made. We offer a variety of ways to pay the charge. We offer cash, card, check, and health savings or flex spending cards. There will be no additional charges for any patient(s) who is seen over 10 visits.

Print _____ Date _____

Sign _____

Scharenberg Chiropractic
421 N Webb Rd.
Wichita, KS 67206
316-945-0075

Visit # _____

BROUGHT BACK TIME_____
START TIME _____
END TIME _____

Patient Name_____DOB_____Date__/___/_____

What would you consider your baby's percentage of **improvement** since **starting** treatment?

0% 5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

When was the last **Bowel Movement**?

How many hours did he/she sleep total last night?

Crying times _____:_____ _____:_____ _____:_____ _____:_____ _____:_____ _____:_____

Circle:

Spitting Up:	Mild	Moderate	Bad		None	
Crying:	Mild	Moderate	Bad	For Pain	For Hunger	Other
Fussing:	Mild	Moderate	Bad		None	
Gassy:	Mild	Moderate	Bad		None	

If Breastfeeding; have you had: Fruits, Tomatoes, Rice, Nuts, Broccoli, Cauliflower, Celery, Lettuce, Chocolate, Caffeine, Cinnamon, Garlic, Onions, Peppers, Eggs, Beef, or Pork?

Has the baby had any new vaccinations or medications?

Is there any information that you would like to share with the Doctor?

Treatment:_____

Prognosis: Unkown Poor Good Fair Excellent

Dennis R. Scharenberg D.C.