



PATIENT INFORMATION

Child's Name \_\_\_\_\_ Parent(s)/Guardian(s) Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Is it okay to contact you at work?  Yes  No      Sex      M      F

E-mail \_\_\_\_\_ Child's Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Have you or your child ever had chiropractic care before?  Yes  No

If yes, please tell us the doctor's name \_\_\_\_\_

Were you pleased with your care?  Yes  No

How did you find out about our office? \_\_\_\_\_

Is this appointment related to an auto accident?  Yes  No

*If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.*

Is your child receiving care from other health professionals?  Yes  No

If yes, please name them and their specialty \_\_\_\_\_

Who is your family's primary care physician? \_\_\_\_\_

Please list any drugs or medications your child is taking \_\_\_\_\_

Please list any vitamins/herbs/homeopathics/other your child is taking \_\_\_\_\_

Please list any allergies your child has \_\_\_\_\_

CURRENT HEALTH

What health condition brings your child to our office? \_\_\_\_\_

When did the symptoms first begin? \_\_\_\_\_

How did the problem start?  Suddenly  Gradually  Post-Injury

Is this condition  Getting Worse  Improving  Intermittent  Constant  Not Sure

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Has your child ever had a similar condition?  Yes  No

Please explain \_\_\_\_\_

Has your child been treated for this problem before?  Yes  No

Please explain \_\_\_\_\_

Does your child eat well?  Yes  No      Does your child have regular bowel/bladder movements?  Yes  No

Has your child ever been checked for vertebral subluxations?  Yes  No  Don't Know

Child's birth was  At home  At a birthing center  At a hospital

My obstetrician/midwife/family physician was \_\_\_\_\_

Child's birth was  Natural vaginal (no medications/interventions)

Vaginal with interventions

Induction  Pain medication  Epidural  Episiotomy  Vacuum extraction  Forceps

Other \_\_\_\_\_

C-section

Scheduled  Emergency

Please list reasons for any interventions/complications \_\_\_\_\_

Child's birth weight \_\_\_\_\_ Child's birth height \_\_\_\_\_ Current weight \_\_\_\_\_ Current height \_\_\_\_\_

APGAR score at birth \_\_\_\_\_ APGAR score after 5 minutes \_\_\_\_\_

Was your child alert and responsive within 12 hours of delivery?  Yes  No

If no, please explain \_\_\_\_\_

At what age did the child:

Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_ Vocalize \_\_\_\_\_

Sit alone \_\_\_\_\_ Teethe \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

Is/was your child breastfed?  Yes  No If yes, how long? \_\_\_\_\_

Formula introduced at age \_\_\_\_\_ What type? \_\_\_\_\_

Introduction of cow's milk at age \_\_\_\_\_ Began solid foods at age \_\_\_\_\_

Please list any foods/juice intolerance \_\_\_\_\_

Did mother smoke during pregnancy?  Yes  No

Did mother drink alcohol during pregnancy?  Yes  No

Any illness of mother during pregnancy?  Yes  No

If yes, please explain including treatment/medications/supplements \_\_\_\_\_

List any drugs/medications (including over the counter) taken during pregnancy \_\_\_\_\_

List any supplements taken during pregnancy \_\_\_\_\_

Any exposures to ultrasound?  Yes  No If so, how many and what was the medical reason? \_\_\_\_\_

Any pets at home?  Yes  No Any smokers at home?  Yes  No

Has child received any vaccinations?  Yes  No

If yes, which ones and list any reactions \_\_\_\_\_  
 \_\_\_\_\_

Has child received any antibiotics?  Yes  No If yes, how many times and list reason \_\_\_\_\_

Any difficulty with breastfeeding?  Yes  No If yes, please explain \_\_\_\_\_

Any difficulty with bonding?  Yes  No If yes, please explain \_\_\_\_\_

Any behavioral problems?  Yes  No If yes, please explain \_\_\_\_\_

Any night terrors, sleepwalking or difficulty sleeping?  Yes  No If yes, please explain \_\_\_\_\_

Age child began daycare \_\_\_\_\_ Average number of hours of TV per week \_\_\_\_\_

Does your child seem normal for their age?  Yes  No If no, please explain \_\_\_\_\_

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Cancer, type _____<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Depression<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G     | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G             | <input type="checkbox"/> Back Problems<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G    |
| <input type="checkbox"/> Heart Disease<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G      | <input type="checkbox"/> Liver Disease<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G  | <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G  | <input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| <input type="checkbox"/> Lung Problems<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G      | <input type="checkbox"/> Scoliosis<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G      | <input type="checkbox"/> Neck Problems<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G        | <input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G     |
| <input type="checkbox"/> Seizures<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G           | <input type="checkbox"/> Osteoarthritis<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |  |

Other \_\_\_\_\_  
 \_\_\_\_\_

Do you know what a subluxation is?  Yes  No

Do any of your friends or relatives see a chiropractor?  Yes  No

If yes, do they use chiropractic for  Health maintenance/optimization  Health problems  Both

Are you seeking chiropractic for  Health maintenance/optimization  Health problems  Both

What would you like to gain from chiropractic care? \_\_\_\_\_  
 \_\_\_\_\_

Are there other health concerns or anything else you'd like us to know about your child? \_\_\_\_\_  
 \_\_\_\_\_

## SYNAPSE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Ranvir Sahota at (916) 625-6395. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

