

Pediatric Health History: Under 13 years old

Oceana Bodyworks

General Information: _____ Today's Date: _____

Child's Name: _____ DOB: _____

Parent or Guardian name(s): _____

Address: _____ City, Zip: _____

Phones: Primary: _____ Other: _____

Email: _____ Referred by: _____

Pediatrician's name and phone: _____

Doctor's name and phone: _____

Child lives with: _____

Allergies (topical and internal): _____

Current medications and supplements: _____

Nightly amount of sleep: _____ Activities and interests: _____

Average stress level and causes: _____

Other alternative therapies child has experienced: _____

Please list primary reasons for seeking CST: _____

Child's Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (In parentheses are examples).

Gestation/Birth (pre-eclampsia, induced labor): _____

Skeletal/ bones (broken bones, scoliosis, back pain): _____

Muscular, Connective Tissue/ muscles, joints (*sprains, torticollis*): _____

Eyes, Ears, Nose, Throat, Mouth (braces, hearing problems, speech, sore throats, ear infections): _____

Is s/he wearing? contact lenses hearing aids

Respiratory/ lungs (asthma, bronchitis, frequent colds, pneumonia): _____

(please continue on other side)

Circulatory/ heart, arteries, veins, blood (hypertension, bleeds or bruises easily, murmurs): _____

Nervous System/ brain, nerves (concussions, ADD and behavioral issues, seizures, ringing in ears, shooting pains, depression):

Digestive & Elimination/stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*): _____

Skin (rashes, psoriasis, eczema, warts): _____

Endocrine/pituitary, hypothalamus, reproductive, thyroid (*growth problems, diabetes*): _____

FOR GIRLS ONLY:

Menstrual History: _____

Anything else (significant family history, car accidents): _____

More details on information listed above: _____

Oceana Bodywork Policies

Your signature below signifies acceptance of the following policies:

Health Information

I have filled out the Pediatric Health History form completely and accurately to the best of my knowledge. I will keep Oceana Bodyworks informed of changes to my child's health or healthcare.

Oceana Bodyworks Scope of Practice

I understand that Oceana Bodyworks does not provide primary medical care, and recommends that my child sees a primary care doctor regularly and I contact them for health care concerns. In case of emergency I will contact 911.

Client Confidentiality

Oceana Bodyworks does not sell client information. I understand that Oceana Bodyworks will not share any of my child's information with any persons or organizations unless 1) required by law to do so or 2) when necessary to consult with other health care professionals to provide optimal care.

Payment and Cancellation

Payment is expected at time of service. Cash, check, or Paypal are accepted.

A 48-hour notice is required for cancellation of an appointment, or I will be charged in full for the appointment. Oceana Bodyworks does not bill insurance companies for missed appointments or late cancellations. I am responsible for paying the missed appointment/late cancellation fees.

Privacy Practices

I have read, understand and been offered a copy Oceana Bodyworks' Private Practices Policy Form (the HIPPA).

Third Party Payment

I understand that, as a courtesy, Oceana Bodyworks bills my insurance directly. It is my responsibility to verify insurance coverage. If the insurance company denies payment or only provides a partial payment, I am responsible for the balance, deductible, and any co-pays. My signature below confirms my financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

I authorize and direct payment of medical benefits to Oceana Bodyworks for services provided by this office.

Release of Medical Records

I authorize the release of all of my child's medical records for the purpose of claims processing, to the following: my attorney, the healthcare providers attending to this condition, and insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through my attorney.

Parent or guardian

Date

Jana Panter
jpanter@OceanaBodyworks.com