Does or did your child have any of the following:

__Frequent illness	Chronic ear infections/ear aches
__Prolonged illness	Frequent runny nose
__Hyperactivity	__Frequent thirst
__Eczema	__Skin Sensitivites

Has your child been on any antibiotics?_____
Approximate # of times_____ Unknown_____

Allergies: Environmental Food
Abnormal bowel movements: Diarrhea Constipation Withholding
Sleep quality: Good Fair Poor
Mood fluctuations: _____

Food:

Approximate consumption per day: Water _____ Milk _____ Soda/Other _____
Favorite foods list: _____
Is your child a picky eater? **Y** **N**
If yes, describe: _____

CONSENT TO EXAMINE, X-RAY, AND TREAT A MINOR

I, the parent or legal represntative of _____ authorize the performance of a diagnostic examination and x-rays of this child or which Leahy Chiropractic P.A. may consider necessary or advisable in the course of treatment.

_____ _____

Signature (Parent's Signature if Patient is a Minor) Date

HIPAA (HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT)

Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Leahy and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (#164.524).

This notice is effective as of _____, 20_____. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature _____ Date _____