Welcome to Secoya Health. We are dedicated to providing you with personalized and preventive care to help you reach your health goals.

Initial visits include: initial consultation; applied kinesiologic and structural exam; body composition analysis, first treatment; and/or other necessary kinesiologic tests. This pediatric initial exam is $125. Additional costs may include: specialized lab testing; nutritional supplements and homeopathic remedies; Bio-Meridian Analysis; special programs; and/or orthopedic appliances.

When you schedule an appointment for your healthcare needs, that time is set aside for you. Given the busy nature of our practice and the high demand for patients to receive care, we charge 1/3 of the exam cost to a credit card to hold your appointment. The 1/3 charged at the time of scheduling will be credited toward your initial exam fee on the day of your appointment. **If you need to cancel or reschedule your initial appointment, we ask that you give a minimum of 72 business hours' notice. If not cancelled within 72 business hours, you will forfeit your appointment reservation fee. All follow up appointments we require 24 business hours' notice for any cancellation**. This will allow us to contact another person on the waiting list. If you cancel within 24 business hours you will be charged for half the appointment. By signing below, you authorize that the card on file can be charged if this notice is not given.

Secoya Health is a "fee for service" practice and payment is due at the time of service. We accept cash, checks, Visa, Discover, and MasterCard. As a courtesy, we do provide our patients with an itemized bill to submit for insurance reimbursement.

The following sheets are very important. Please answer all of the questions thoroughly at least three days before your appointment and bring them with you to your initial exam. Please wear comfortable clothing & shoes to your appointment.

IMPORTANT: **Do not consume any *nutritional supplements* the day of your appointment.** Also, we ask that you bring any medications and/or nutritional supplements (vitamins, herbs, oils, etc.) you deem necessary in your health routine. Out of respect for those patients who are sensitive, we also ask that you refrain from wearing any perfumes or colognes for your appointments at Secoya Health

We ask that you arrive **15 min. early** to your initial appointment.

Thank you for choosing Secoya Health for your healthcare needs.

Patient's signature ____
(or guardian)

Date ______________

Mandatory Disclosures

Informed Consent for Chiropractic Treatment

Chiropractic adjustments are a conservative and very safe procedure. We are required by law to notify you of any risk involved. The only serious complication of a chiropractic adjustment is a vertebral artery injury, commonly known as a stroke. It is extremely rare – statistics show this may occur about once in a million to once in 10 million adjustments. Most importantly, there has never been a case of vertebral artery injury at this clinic.

______ I understand the remote possibility of injury from chiropractic treatment and elect to receive the recommended treatment.

Privacy Policies and Authorizations

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We have always been very concerned with protecting your privacy, but now the federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice will remain in effect until further notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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 within this clinic in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities such as reviewing office procedures and training staff. Patient information will be disclosed in hardcopy only. No fax or internet transmissions will be sent.

We may also disclose your health information with your written consent. Your authorization may be revoked in writing at any time. Your revocation will take effect upon receipt. Any authorization you have signed that we receive from any other source will also be considered valid.

Your Family and Persons Involved in Your Care: We ask that patients take responsibility to make and cancel their own appointments, except in the case of minors or disadvantaged adults. We confirm your appointment time by telephone and may leave a message on either a voicemail or with another person in your household if you are not available. We will also use our professional judgment when allowing another person to pick up supplements or requested information relayed on your behalf.

You have the right to get a copy of your health record by giving us a written request. We reserve the right to charge for copying costs at a rate of $.90 per page and a $12.00 retrieval fee.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging I have received a copy of this authorization.

______________________________	______________________________	______________________
Patient Name	Patient Signature	Date
______________________________	______________________________	
Personal Representative	Personal Representative Signature	

ESSENTIAL PATIENT INFORMATION --- Child

Name ____

Last First M.I.

Male____ Female____

Address___________________________________ _____ Home Phone____________________________________

City____ Guardian's Cell Phone____________________________

State_______________ Zip______________________

Age _____

Date of Birth_______________________________

Preferred Method of Contact (circle one): Phone/E-mail/Text/All

Guardian/Parent ____

Occupation or Profession____

Employed by____ Business Phone___________________________

Guardian/Parent ____

Employed by____ Business Phone___________________________

Referred by____

Has you child had chiropractic care before? ___________________

Where? ____

Has your child had an X-ray in the last year? ___________________ Where? ________________________

Initial Exam: ______________________________________

GUARDIAN MUST BE PRESENT AT INITIAL VISIT

Pediatric Medical History

Name ___________________________ Date__________________

Nickname__________________________

Essential Information

Present Complaint____

____

____

____

Associated Problems____

____

____

History of Present Illness

First Noticed______________________

How did the present issue begin and has it changed over time?

____

____

____

Effect of Illness on Behavior____

____

____

List physicians seen for this issue and/or labs ____

____

____

____

____

____

History of Past Illness

Neonatal:
Degree of Activity/Apgar Score____

Health problems (respiratory distress, jaundice, anomalies, infections, feedings)____________________

____

Birthmarks/Location____

Nutritional:
Breastfed or Bottle (formula)____

Schedule____

Time of introduction of solids (which foods)_____________________________________

Time of weaning and response to weaning______________________________________

Foods allergies, favorite foods, feeding problems, colic, regurgitation___________________

____

Use of supplements (vitamins, minerals, herbs, fluoride)______________________________

____

Appetite and attitude towards food____

____

Growth and Development
Birth weight____________ Height________________

Ages of Developmental Milestones
Head control_____________________
Smile____________________________
Sitting___________________________
Standing_________________________
Walking__________________________

Sleep patterns (full night sleep, nightmares, sleep walking, restlessness)____________________

____

Toilet Training (age of control, bed-wetting, encopresis “fecal retention”)____________________

____

Habits (thumb sucking, nail biting, rocking, head banging, cravings for ground soil, chalk, etc.)___________

____

Discipline and Acceptance (tantrums, aggression, withdrawal, destructive behavior)_______________

____

Social Adjustments (separation anxiety, development of independence, shyness, friends, hobbies, sports)______________

____

____

Prenatal (Mother's health history):
Health/ Illness/Problems____

____

____

Nutrition____

____

Attitudes (emotional state during pregnancy, planned/unplanned birth, living circumstances)__________________________

____

____

Labor/delivery (vaginal/C-section/forceps/complications)____

____

____

Family Health History

Relation	**State of Health (if living)**	**Age at Death**	**Cause of Death**	Check (x) if your blood relatives have/had: **Disease**	**Relationship**
Father				**Arthritis, gout** ______ **Asthma, hay fever**	______
Mother				**Cancer** ______ **Chemical dependency**	______
Brothers				**Diabetes** ______ **Heart Disease, Stroke** ______ **High blood pressure**	______ ______
Sisters				**Syphilis, gonorrhea** ______ **Tuberculosis** ______ **Other**	______ ______

Please list everything your child eats and drinks for 2-3 days; if in sooner, a typical day:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Medical Survey

Immunization (reactions, childhood diseases – DPT, Polio, Measles (Rubeola), German Measles (Rubella))____________

____

____

Childhood Illnesses (circle the ones your child has presently, or has had in the past)

ADHD	Asperger's	Anemia	Asthma
Bleeding Disorders	Bronchitis	Cancer	Chicken Pox
Diabetes	Fractures	Ear Infections	Heart Disease
Hepatitis	Hernia	Herpes	HIV positive
Mumps	Measles	High Blood Pressure	Kidney Disease
Liver Disease	Migraines	Mononucleosis	Multiple Sclerosis
Pneumonia	Polio	Psychiatric Care	Suicide Attempt
Thyroid Problems	Tonsillitis	Tuberculosis	Tumor/growths
Whooping Cough	other________________		

Signature of Guardian ____

Relationship to Patient____

Date ____________________________________