

158 DANBURY ROAD ~ RIDGEFIELD, CT 06877

CHILD MEDICAL AND HEALTH HISTORY

A. Identification

Child's Name: _____ Age: _____ Birthdate: ___/___/___ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____ (C) _____ (F) _____ Parent's email: _____
Social Security # _____ How did you hear of us? _____
Mother's Name: _____ Father's Name: _____
Parent's Family Status: Married / Divorced / Separated / Never Married (circle one)
Emergency Contact: _____ Phone: _____

B. Insurance Information

Primary Insurance: _____ Policy #: _____ Group ID: _____
Patient's relationship to insured: Child / Other
Insured's Name (holder of policy): _____ Insured's DOB: _____
Secondary Insurance: _____ Policy #: _____ Group ID: _____
Patient's relationship to insured: Child / Other
I AM THE PARENT OR LEGAL GUARDIAN AND AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO
PROCESS THIS AND RELATED CLAIMS. I REQUEST PAYMENT TO MYSELF OR TO THE PARTY WHO PROVIDED THE CARE.
Signature _____ Date _____

c. Chief Complaint

Please list your child's major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation). Please rank in order of severity.

Table with 2 columns: PROBLEM AND/OR SYMPTOM, DATE PROBLEM BEGAN. Contains 5 empty rows for data entry.

If you have seen other practitioners for these problems, indicate the results of these evaluations:

Two horizontal lines for writing the results of other practitioners' evaluations.

D. Family Medical History

Please indicate if you, the parents have had any of the following problems in the past. Please note years affected and if mother or father has particular problem.

Alcoholism		Depression		Herpes		Lyme Disease		Smoker	
Allergies		Diabetes		HIV		Mental Illness		Thyroid Disease	
Anemia		Digestive Disease		Hypoglycemia		Migraine Headache			
Arthritis		Drug Problems		Hepatitis		Multiple Sclerosis			
Asthma		Eating Disorder		High Blood Pressure		Prostate Disease			
Cancer		Eczema		Irritable Bowel		Rheumatic Fever			
Celiac Disease		Emphysema		Kidney Disease		Seizures			
Crohn's Disease		Heart Disease		Lupus/AutoImmune		Stomach/Intestinal Ulcers			

How many siblings does the child have? _____

Please list names, ages and any medical problems.

Name	Age	Medical Problems?

E. Prenatal History (For mother to complete)

Did you smoke during pregnancy? Yes / No Did you drink during pregnancy? Yes / No

Did you receive immunizations for flu or tetanus? Yes / No Did you receive rhogam? Yes / No

Did you have gestational diabetes? Yes / No Did you have pre-eclampsia (high blood pressure)? Yes / No

Did you have any serious illnesses? Yes / No

If so, please explain: _____

F. Perinatal Period (For mother to complete)

Was your child born prematurely? Yes / No if so, how many weeks? _____

Did you experience any complications during delivery? Yes / No If so, please detail and note any medications you may have been given: _____

Did your child need any special care after delivery? Yes / No If so, please explain: _____

G. Early Childhood

Has your child been diagnosed with any chronic medical conditions to date? Yes / No If so, please list and note who diagnosed condition:

DIAGNOSIS	DOCTOR

Was your child breastfed? Yes / No If so, for how long? _____

Has your child frequently been treated with antibiotics for respiratory or ear/throat infections? Yes / No If so, approximately how many times? _____ Were there any delays in developmental milestones? Yes / No If so, please explain: _____

H. Immunizations: Specify when received if known (or attach copy of immunization schedule):

IMMUNIZATION	DATES RECEIVED	IMMUNIZATION	DATE RECEIVED
Polio (oral / shot)		Hemophilus Influenza (HIB)	
Measles / Mumps / Rubella		Pnemococcus (PCV)	
Diphtheria/Pertussis/Tetanus			
Hepatitis B			
Chicken Pox			

I. Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

J. Current Medications / Supplements

Please write name, dosage and how often taken.

PRESCRIPTION/OVER THE COUNTER MEDICATIONS	SUPPLEMENTS

Please list any medications your child may have an allergy to and the type of reaction: _____

Environment

Are there any pets in the house? Yes / No If yes, please list type(s) _____

Is the child's room carpeted? Yes / No Does any family member smoke in the house? Yes / No

Please complete primary care provider or pediatrician information:

Name: _____ Address: _____ Phone: _____

If you have a specialist, please complete:

Name: _____ Address: _____ Phone: _____

Specialty _____

K. Review of Systems

Please check next to the symptoms that you have experienced over the past 6 months.

General	Skin	Eyes	Ears	Nose
Fevers	Dryness	Eye Pain	Excessive Wax	Runny Nose
Night Sweats	Rashes	Redness	Discharge	Nasal Discharge
Insomnia	Itching	Discharge	Itching	Sneezing
Frequent Colds/Flu	Nail Fungus	Itching	Ringing / Tinnitus	Frequent Bleeding
Fatigue	Brittle Nails	Excessive Tearing	Decreased Hearing	Frequent Snoring
		Dryness		
		Blurred Vision		
		Poor Night Vision		
Mouth	Throat	Endocrine	Cardio/Pulmonary	Gastrointestinal
Oral Sores	Frequent Soreness	Intolerance to Heat	Shortness of Breath	Heartburn
Funny Taste	Difficulty Swallowing	Intolerance to Cold	Palpitations	Bloating/Gas
Bad Breath	Painful Swallowing	Shakiness	Cough	Nausea
Coating on Tongue	Change in Voice	Fatigue	Chest Pain	Vomiting
	Frequent Clearing Throat	Increased Appetite	Leg Cramps when Walking	Hemorrhoids
	Hoarseness	Decreased Appetite	Leg Cramps at Night	Black or Dark Stools
		Weight Gain/Loss	Varicose Veins	Blood in Stools
		Sweat Easily	Lightheadedness	Constipation
		Cold Hands/Feet	Passed Out	Diarrhea
		Hair Loss/Thinning	Leg Swelling	Thin Stools
		Excess Facial Hair		
		Eyebrows Thinning		
Neurological	Mental/Emotional	Musculoskeletal	Genitourinary	Men Only
Numbness of a Limb	Anxiety	Joint Pain	Difficulty Urinating	Testicular Lumps
Weakness of a Limb	Depression	Muscle Aches	Cloudy Urine	Penile Discharge
Tension Headaches	Suicidal Thoughts	Back Pain	Involuntary Loss of Urine	Penile Lesions
Migraine Headaches	Panic Attacks	Morning Stiffness	Frequent Urination	Impotence
Room Spinning	Nervousness		Nighttime Urination	Breast Enlargement
Head Trauma				
Memory Loss				

L. Diet Survey

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

Frequent = at least once per day **Often** = several times/week **Occasional** = once/week or less **Seldom** = once or twice/month or less
Never = almost total avoidance

	Frequently	Often	Occasional	Seldom	Never
Alcoholic Beverages					
Eat at Restaurants					
Eat at Fast Food Restaurants					
Pastries, Cookies, Candies, Ice Cream, Other Sweets					
Add Sugar to Coffee, Tea, Cereals, Other Foods					
Colas or Other Soft Drinks					
Instant Breakfasts, Pop Tarts, Doughnuts, Muffins					
Cold Breakfast Cereals					
Caffeine Drinks (Coffee, Tea, Cola, Chocolate)					
Deep Fried Food					
Margarine of any Type					
Whole Grain Hot Cereals (Oatmeal, Wheatena, etc.)					
Meat (Beef or Veal, Pork or Ham, Lamb, Liver)					
Chicken or Turkey – Regular or Free Range?					
Fresh Fish					
Processed Meat (Bologna, Turkey Roll, Sausage, etc.)					
Fresh Raw Fruit					
Fresh Vegetables, Raw or Cooked					
Salads					
Whole Grains or Whole Grain Breads					
White Bread or White Flour Products					
Beans and Legumes (Lentil, Kidney, Chickpea, etc.)					
Yogurt – Whole or Lowfat, Plain or Flavored (circle)					
Milk – Whole, Lowfat, or Skimmed (circle)					
Cheese					
Eggs – Regular or Free Range (circle)					
Salt					
Herbs, Fresh and Dried, or Spices					
Drink Adequate Water – Tap, Filtered, Bottled (circle)					
Eat Excessively if Bored or Depressed					
Swallow Food Before Chewing Well					
Hurried or Rushed Meals					
Stuff Yourself					
Read and Understand Food Labels					
Sneak or Hide Foods					
Adequate Fiber or Roughage in Diet					
Artificial Sweeteners (Saccharin, Nutrasweet, etc.)					
Shop at Health Food Stores					

OSTEPATHIC WELLNESS CENTER, LLC FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

___ Patient with Insurance: You are responsible for deductibles, copays, non-covered services, coinsurance, and items considered “not medically necessary” by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

___ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet without billing specialist.

___ Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

___ Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any non-covered services.

___ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker’s compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

___ Non-participating provider: We do not participate with _____. If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

OSTEOPATHIC WELLNESS CENTER, LLC

GUARANTEE OF PAYMENT

Please initial each section on the line provided.

____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

____ I have been advised that if my health insurance carrier/HMO/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

____ I authorize payment of benefits from my insurance carriers directly to Osteopathic Wellness Center. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying Osteopathic Wellness Center].

____ **Cancelation Policy:**

I understand that there is a \$75 reinstatement fee charged if I miss or cancel my appointment (with less than 24 hours notice) three or more times in a 12 month period. This fee must be paid prior to scheduling another appointment.

____ **Minor Patients only:**

The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE

THERE WILL BE A \$25.00 FEE FOR RETURNED CHECKS

For your convenience, we also accept VISA and MasterCard.

I have read and understand my financial responsibilities as outlined in both pages of this Osteopathic Wellness Center Financial Policy document.

X _____

Patient's Signature

Date

Patient's Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

OSTEOPATHIC WELLNESS CENTER, LLC CONSENT FORM / PRIVACY NOTICE

Please initial each section on the line provided.

____ **Consent for Treatment:**

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

____ **Medical Release Authorization:**

With my consent, Osteopathic Wellness Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

To review the more comprehensive version of this notice or if you have any questions, please contact our office administrator at 203-438-9915

Osteopathic Wellness Center is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy

At Osteopathic Wellness Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

____ **Consent for Contact:**

With my consent, Osteopathic Wellness Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

OSTEOPATHIC WELLNESS CENTER, LLC

Practice Duties – Regarding your health care information

Osteopathic Wellness Center is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Osteopathic Wellness Center is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information

The patient has the right to request the practice to restrict use and disclosure of protected health information. Osteopathic Wellness Center is not required to agree to the requested restriction.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Osteopathic Wellness Center’s use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Osteopathic Wellness Center may decline to provide treatment to me.

X _____

Patient’s Signature

Date

Patient’s Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

What to Expect After Treatment:

While osteopathic treatment is unique to every individual, there are several things that will help you to better understand the treatment process.

1. After the initial one or two treatments, occasionally you may feel worse before you notice any relief. This is because as your self-healing mechanism is activated, your body continues to readjust as it integrates the treatment. This usually passes after several hours or may last up to a full day or so.

For increased pain after a treatment, we usually recommend Topricin cream (topical homeopathic) applied to all painful areas 2 to 3 times daily. Please continue using this as prescribed, as it will speed up the healing of tissues, as well as provide pain relief. Bach Rescue Remedy is sometimes prescribed to help the treatments to integrate better for the first month. It is also good for very stressful events (physical or emotional). Take 1 dropperful under the tongue, every 1 to 2 hours. Saloxicin (a natural anti-inflammatory can also be taken, 2-3 tabs 3 times daily). A 20-minute bath with Epson salt or sea salt will help to draw toxins out of the body and provide muscle relaxation. Tylenol or Motrin may be used if pain is more severe.

Often nutritional support will also be recommended to further speed up the body's healing process. We will often recommend Metagenics or Xymogen or other high quality nutritional supplements. It is best to take them as prescribed with meals to improve absorption. It is important to continue using the multivitamin/mineral supplement, Multigenics, (Active Nutrients), EPA/DHA (fish oil), and Calcium Magnesium (Ossipan MD) indefinitely, as most of us are deficient in these nutrients. Wait 102 days before starting each new product to allow time to adjust. Other supplements can be decreased after a few months depending on your blood work and overall level of health. If you run out of your supplements, you may order more by calling Xymogen at 800-647-6100, Acct# JOHNSTD. If you wish, Metagenics supplements, please consult with the Office Manager.

2. You may notice significant improvement, some improvement, or none at all after the first treatment. On average, it takes about 4 to 5 treatments to begin to experience relief from the original complaints. This varies tremendously with each person based on their overall level of health, which depends on various factors (multiple medical problems, number of prescription medications, amount of exercise, quality of diet, lifestyle stressors and old injuries and surgeries.)

Usually, you will return for follow-up in a few days or a week later. The initial treatments will usually be spaced apart by a few days or up to a week or two. As Dr. Johnston assesses your system at each visit, he will determine when it is best to return. Treatment can last from 20-35 minutes depending on what your body will accommodate for that day. As your systems begin to improve and your nervous system and cranial mechanism improves, we will begin to space out treatments by an extra week or so. After you have recovered, it is still recommended that you return in 4 to 6 weeks for a maintenance (tune up) treatment. Osteopathic treatment can prevent many problems before they surface and keep you in overall good balance, alignment and health.

3. It is helpful to refrain from chiropractic and other manual treatments during osteopathic treatment to better evaluate your response. Gentle massage, acupuncture, shiatsu, and occasionally other treatments may be done one to two days before or after osteopathic treatment. Please check with Dr. Johnston to be sure. After your treatment, it is helpful, if you can relax for 30-60 minutes to get the optimum benefit. You may feel very tired after a treatment if it is your first one or if it has been several months since your last visit. If you are exhausted, please listen to your body and go to bed early that evening.

4. Often times, after patients start to feel better, they go back to their normal activity too soon and end up overdoing it. This can cause the strain pattern to return and feel like your pain and other symptoms have returned. This is actually only a minor setback and one or two treatments will correct this.

Please limit your normal activity (vigorous workouts, golf, yoga, weight training, gardening, lifting, bending over, etc.) as much as possible during the first few treatments. Please ask Dr. Johnston questions about specific activities you may do and how to modify them. Usually, you are the best judge, so please listen to your body and allow it time to rest and heal.

5. Dr. Johnston often will recommend gentle stretching and deep breathing and relaxation exercises initially and then more extensive core strengthening programs and exercises from Dr. Fulford's book, "The Touch of Life". It is very important to do these exercises as prescribed, as they are part of the treatment and healing process. The core muscles, when strengthened correctly, will enable you to gain a greater awareness of your body and your everyday movements, as well as to maintain better alignment and postural stability. This will lead to longer lasting effects from each osteopathic treatment and quicken recovery. **The Core Program**, by Peggy Brill, PT is a terrific book to start with, Core I, every other day for the first 4-6 weeks.
6. Remember; please ask questions if you have any. The Osteopathic Resource Sheet lists several places to find more specific details about osteopathy. **The Touch of Life**, by Robert Fulford, DO is highly recommended quick reading to explain Osteopathy. As one of my patients told me, if they had not read Dr. Fulford's book, they would not have understood the treatment I was doing! You can leave a message anytime on the machine and Dr. Johnston will return your call as soon as possible. Osteopathic treatment is unique for each individual and everyone responds to the treatment at different rates. This is because the body's healing mechanism is unique for each person.

Thank you for your commitment to osteopathy and allowing me to assist you in your healing process.

David L. Johnston, DO

OSTEOPATHIC RESOURCES

WEBSITES

- www.osteopathicwellness.net
- www.cranialacademy.org
- www.osteohome.com – Dr. Dolgin
- www.academyofosteopathy.com
- www.setf.com
- www.osteopathic.org – AOA Site for parents
- www.osteopathiccenter.org – Dr. Frymann / children

BOOKS

- **The Touch of Life** – Robert Fulford, D.O.
- **The Difference a DO Makes** – Bob Jones
- **The DOs – Osteopathic Medicine in America** - Norman Gevitz

ARTICLES

“Healing and the Natural World”

James Jealous, D.O. - Alternative Therapies, January, 1997, Vol. 3

“Osteopathy in the Cranial Field: The Approach of W.G. Sutherland, D.O.”

Rachel Brooks, M.D.- Physical Medicine and Rehabilitation: State of the Art Reviews,
Vol. 14, No. 1, February, 2000. Philadelphia, Hanley and Belfus, Inc.

“The Osteopathy Alternative”,

Susan Rubenstein December 1990 East/West