



Lydia H. Knutson, D.C. • Theresa Hopkins, D.C.
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This information is strictly confidential. Your answers will help us determine if chiropractic can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible.

I understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received unless definite financial arrangements are made in advance.

I hereby authorize Dr. Lydia Knutson or Dr. Theresa Hopkins to examine and treat my child's condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Parent or Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE DO NOT WEAR PERFUMES, AFTERSHAVES OR OTHER SCENTS TO THIS OFFICE.
SOME PATIENTS ARE ALLERGIC.

PATIENT INFORMATION

Name \_\_\_\_\_ Today's Date \_\_\_\_\_
Address \_\_\_\_\_ Parent Name(s) \_\_\_\_\_
City, State, Zip \_\_\_\_\_ Parent Occupations(s) \_\_\_\_\_
Phone (home) \_\_\_\_\_
Social Security Number \_\_\_\_\_ Parent Employer(s) \_\_\_\_\_
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_
Gender: [ ] F [ ] M Height: \_\_\_ ft \_\_\_ in Weight: \_\_\_\_\_ Parent Email \_\_\_\_\_
Medical Doctor \_\_\_\_\_ Parent Work Phone \_\_\_\_\_
Date of last check-up \_\_\_\_\_ Parent Cell Phone \_\_\_\_\_
Travel time to this office \_\_\_\_\_ Referred to our office by \_\_\_\_\_
Name/ Age of Sibling(s) \_\_\_\_\_
Other Household Members (include extended family, non-family and pets) \_\_\_\_\_
Name of person responsible for payment of professional services \_\_\_\_\_

CURRENT HEALTH REPORT

What are the primary health or developmental concerns with this child?

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## BIRTH HISTORY

Term: Full / Premature / Late C-Section? \_\_\_\_\_ Did mother go into labor? \_\_\_\_\_ Length of Labor \_\_\_\_\_

Weight at Birth \_\_\_\_\_ Birth/fetal pregnancy complications \_\_\_\_\_

Feeding:  Breast fed How long? \_\_\_\_\_  Formula  Milk/Soy Solid foods at age \_\_\_\_\_

Baby's sleep pattern first year \_\_\_\_\_

Does child sleep well now? \_\_\_\_\_

As a baby did this child experience:

- |  |                                   |                                   |                                   |
|--|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Colic    | <input type="checkbox"/> Fever    | <input type="checkbox"/> Rashes   |
| <input type="checkbox"/> Birth Injury  | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Defects |                                   |                                   |                                   |

## DEVELOPMENTAL HISTORY

### Physical Development

Age began: Rolling over \_\_\_\_\_ Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Any difficulties with:

- |                                       |                                      |   |
|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Rolling Over | <input type="checkbox"/> Running     | <input type="checkbox"/> Activities on a Play Structure |
| <input type="checkbox"/> Crawling     | <input type="checkbox"/> Somersaults | <input type="checkbox"/> Gross Motor Activities         |
| <input type="checkbox"/> Walking      | <input type="checkbox"/> Climbing    | <input type="checkbox"/> Fine Motor Activities          |

If any difficulties, please explain: \_\_\_\_\_

Unusual Skills or Interests \_\_\_\_\_

### Sensory Integration Issues

Sensitivity to:  Light  Sound  Smells  Tactile Stimulation  Picky Eater (texture/taste)

### Language Development

Age of First Words \_\_\_\_\_ Sentences \_\_\_\_\_

### Daily Activities

How many hours does your child spend playing out of doors each day? \_\_\_\_\_

How many hours does your child spend on computer, TV or video time? \_\_\_\_\_

Favorite Activities: \_\_\_\_\_

### Social Development

Desire and ability to communicate with:

Parents \_\_\_\_\_ Peers \_\_\_\_\_ Adults \_\_\_\_\_

Siblings \_\_\_\_\_ Older Children \_\_\_\_\_ Strangers \_\_\_\_\_

Describe his/her relationships with siblings: \_\_\_\_\_

Emotional traumas: \_\_\_\_\_

Extended family (or committed adult family friends) with whom the child has regular contact: \_\_\_\_\_

Notable developmental histories of biological siblings: \_\_\_\_\_

## DIET

Please describe your child's typical daily diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Sweets \_\_\_\_\_

Food cravings: \_\_\_\_\_

Any known food, environmental or medication allergies/intolerances? Please list: \_\_\_\_\_

\_\_\_\_\_

Does your child routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what? \_\_\_\_\_

\_\_\_\_\_

Artificial colors/sweeteners? \_\_\_\_\_ Has child ever tried a gluten free/dairy free diet? \_\_\_\_\_

## MEDICAL HISTORY

### Injuries

Head injuries \_\_\_\_\_

Other major falls or injuries \_\_\_\_\_

Other traumatic events ( \_\_\_\_\_

Surgeries/Hospitalizations \_\_\_\_\_

### Infections

Has this child had any of the following infections:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Pneumonia     | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles        | <input type="checkbox"/> Rubella       | number of times ____                    |
| <input type="checkbox"/> Croup       | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ear Infections |

Approximate number of antibiotic prescriptions in child's lifetime \_\_\_\_\_ number of times \_\_\_\_

### Immunizations

Has your child had standard childhood vaccinations?  yes  no Any adverse reactions? Please describe: \_\_\_\_\_

\_\_\_\_\_

When your child's condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? \_\_\_\_\_

## Symptoms

Please circle: **Y** = current condition **N** = never had **P** = has had in the past

Y N P acne	Y N P frequent urination	Y N P flat feet
Y N P excema	Y N P bloody urine	Y N P joint pains
Y N P hives	Y N P hearing loss	Y N P nervousness
Y N P asthma	Y N P heart murmur	Y N P dizzy spells
Y N P high fevers	Y N P anemia	Y N P body/breath odor
Y N P chronic rash	Y N P stomach aches	Y N P motion/car sick
Y N P canker sores	Y N P constipation	Y N P nightmares
Y N P sore throat	Y N P diarrhea	Y N P unusual fears
Y N P sinusitis	Y N P gas	Y N P night sweats
Y N P wheezing	Y N P no appetite	Y N P cries easily
Y N P bleeding gums	Y N P insatiable hunger	Y N P inconsolable crying
Y N P nose bleeds	Y N P jaundice	Y N P excessive fatigue
Y N P burning urination	Y N P bruises easily	

Any other condition not previously mentioned \_\_\_\_\_

Any current medications (prescription and non-prescription): \_\_\_\_\_

## IMAGING AND SPECIAL STUDIES

	When	Where	Results
Hearing Test	_____	_____	_____
Vision Test	_____	_____	_____
Speech/Language	_____	_____	_____
Behavioral Assessment	_____	_____	_____
X-ray	_____	_____	_____
Other _____	_____	_____	_____

## FAMILY HISTORY

Has any immediate family member had any of the following:

- |                                    |  |  |   |
|------------------------------------|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |

Health of biological siblings \_\_\_\_\_

Previous pregnancies by birth mother, miscarriages or complications \_\_\_\_\_

Mother's health during pregnancy:

- |  |                                     |   |                                      |
|--|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Alcohol consumption       | <input type="checkbox"/> Drug use   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Bleeding                  | <input type="checkbox"/> Illness    | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Physical/emotional trauma | Mother's age at child's birth _____ |   |                                      |



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617-876-9011 fax

ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a  
(Please Print Name)

copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(If Patient is a Minor, Please Print Name)

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- € Individual refused to sign
- € Communications barriers prohibited obtaining the acknowledgement
- € An emergency room situation prevented us from obtaining acknowledgement
- € Other (Please specify) \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

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### OUR LEGAL DUTY

We are required by applicable federal and state law 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. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for a treatment or upon request. If we make a change in our privacy terms the change will apply for all of your health information in our files.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### 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 or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, or your location, general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our best professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up x-rays or similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or enforcement officials having lawful custody of protected health information of inmate or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expense such as copies and staff time. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

**Disclosure Accounting:** You have the right to receive a list of instances in which we have disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). If we do not agree to your restrictions, you may drop your request or you are free to seek care from another healthcare provider.

**Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**To Contact us:**

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