

# The Khoury Centre For Health and Wellness

640 Washington Street  
Dedham, MA 02026  
(781) 329-3344

116 Mechanic Street #3  
Bellingham, MA 02019  
(508) 966-3777

Wassim G. Khoury, D.C  
Dawn-Marie Khoury, D.C., D.I.C.C.P.  
Ryan Davis, D.C.

## PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information*.

\_\_\_\_\_  
Parent/Guardian Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Witness Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

Name of Child: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_  
 Name of Emergency Contact: \_\_\_\_\_  
 Phone Number of Emergency Contact: \_\_\_\_\_  
 Child's primary language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Name of Primary Care Physician (Pediatrician): \_\_\_\_\_  
 PCP Address: \_\_\_\_\_

Name of Parent: \_\_\_\_\_  
 Parent's Address (if different from child): \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Child's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
 # of weeks of Pregnancy with child: \_\_\_\_\_  
 Referred To This Office By: \_\_\_\_\_

Who is Responsible For Your Child's Bill:  You  Spouse  Auto Insurance  Medicare  
 Personal Health Insurance Co.: \_\_\_\_\_ Health Card Number: \_\_\_\_\_  
 Insured Person's Name: \_\_\_\_\_ Insured Person's Date of Birth: \_\_\_\_\_

List any concerns you have about your child's health: \_\_\_\_\_

<p><b>YES NO REGARDING PREGNANCY:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Did your diet include sugar, white flour, or trans fats?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience any back pain during pregnancy?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you consume any alcoholic beverages during pregnancy?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you smoke cigarettes, drink caffeine, or take medications?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you receive any vaccinations or shots?</p> <p><input type="checkbox"/> <input type="checkbox"/> Were you physically ill at any time?</p> <p>List medications taken during pregnancy: _____</p> <hr/> <p><b>YES NO REGARDING LABOR/DELIVERY:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience back pain during labor?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did you experience a difficult or prolonged labor?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your delivery extremely rapid?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your baby's presentation head down?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your baby posterior or breech?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was another individual supporting you during labor and delivery?</p> <p>Did the delivery involve any of the following:</p> <p><input type="checkbox"/> <input type="checkbox"/> Forceps</p> <p><input type="checkbox"/> <input type="checkbox"/> Vacuum suction</p> <p><input type="checkbox"/> <input type="checkbox"/> C-section</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulling or twisting of your baby</p> <p><input type="checkbox"/> <input type="checkbox"/> Pitocin (chemically induced labor)</p> <p><input type="checkbox"/> <input type="checkbox"/> Epidural</p>	<p><b>YES NO NUTRITION:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Did you breast feed your child? If yes, for how long? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Did your child have difficulty latching on? Was your baby formula-fed?</p> <p><input type="checkbox"/> <input type="checkbox"/> If yes, what type/brand of formula? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Were solid foods introduced before 6 months?</p> <p>Did your baby's diet include any of the following <b>before 1 year old</b>:</p> <p><input type="checkbox"/> <input type="checkbox"/> Cow's milk</p> <p><input type="checkbox"/> <input type="checkbox"/> Soy</p> <p><input type="checkbox"/> <input type="checkbox"/> Sugar</p> <p><input type="checkbox"/> <input type="checkbox"/> Trans-Fats</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheat/Grains</p> <p><input type="checkbox"/> <input type="checkbox"/> White Flour</p> <p><input type="checkbox"/> <input type="checkbox"/> Nuts</p> <p><input type="checkbox"/> <input type="checkbox"/> Corn</p> <p>Does your child's diet include any of the following <b>currently</b>?</p> <p><input type="checkbox"/> <input type="checkbox"/> Cow's milk</p> <p><input type="checkbox"/> <input type="checkbox"/> Sugar</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Sweeteners (Splenda, Nutrasweet)</p> <p><input type="checkbox"/> <input type="checkbox"/> Soda</p> <p><input type="checkbox"/> <input type="checkbox"/> White Flour</p> <p><input type="checkbox"/> <input type="checkbox"/> Grains or Wheat</p> <p><input type="checkbox"/> <input type="checkbox"/> Trans Fats (margarine, packaged foods, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> Soy</p> <p><input type="checkbox"/> <input type="checkbox"/> Does you child have any allergies?</p>
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Where was your child delivered:  Home  Birthing Center  Hospital  
 List any allergies (food or environmental): \_\_\_\_\_  
 \_\_\_\_\_  
 List your baby's first foods: \_\_\_\_\_  
 List your child's favorite food: \_\_\_\_\_

**YES NO EMOTIONAL HEALTH:**  
  Does your child fail to follow directions?  
  Is your child hyperactive?  
  Does your child have difficulty socializing with others?  
  Does your child have frequent "temper tantrums?"  
  Does your child get frustrated easily?  
  Other behavioral problems: \_\_\_\_\_

**YES NO MEDICAL HISTORY:**  
  Has your child ever taken an antibiotic?  
 Total Number of antibiotic prescriptions: \_\_\_\_\_  
 Reason for antibiotics: \_\_\_\_\_  
  Did your child receive any vaccinations?  
  If yes, did your child experience any behavioral or physical changes after vaccination?  
 Describe reactions: \_\_\_\_\_  
  Has your child ever been hospitalized?  
 Reason and date of hospitalization: \_\_\_\_\_  
  Has your child had any surgeries?  
 List surgeries: \_\_\_\_\_  
  Exposure to ultrasound? How many and what was the medical reason? \_\_\_\_\_

**YES NO FAMILY HISTORY:**  
  Do any other family members have health problems?  
 List siblings:  
 Brother(s): Age(s) \_\_\_\_\_  
 Sister(s): Age(s) \_\_\_\_\_

**GROWTH AND DEVELOPMENT:**  
 At what age did your child sit up? \_\_\_\_\_ months  
 At what age did your child crawl? \_\_\_\_\_ months  
 At what age did your child walk? \_\_\_\_\_ months  
 At what age did your child talk? \_\_\_\_\_ months  
 Child's Height and Weight at Birth:  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 APGAR scores at birth: \_\_\_\_\_  
 Child's Height and Weight at Last Physical:  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 List any concerns about your child's growth and development:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 List your child's current medications and/or Supplementation/vitamins: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**YES NO PHYSICAL TRAUMA :**  
  Did your child ever fall when learning to sit-up, stand, walk, run, ride a bike, play sports?  
  Has your child ever fallen down, tripped, or hit his/her head?  
  Has your child ever fallen from a height greater than 2ft?  
  Has your child ever broken a bone, dislocated or sprained a joint?  
  Has your child ever been in a motor vehicle accident? Date of accident: \_\_\_\_\_  
  Does your child carry a backpack greater than 15% of his/her body weight?  
  Does your child spend more than 1 hour per day in front of the TV, video games, or computer?  
  Did his/her mother ever fall when pregnant with this child?

List sports played and age began:  
 \_\_\_\_\_  
 \_\_\_\_\_

**HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING HEALTH PROBLEMS?**

**YES NO**  
  Torticollis/Wry neck  
  Reflux/vomiting  
  Failure to thrive/difficulty gaining weight  
  Difficulty turning head to one side  
  Hyperactivity/ADD  
  Ear Infections  
  Difficulty Sleeping  
  Bed Wetting  
  Irritability  
  Colic  
  Frequent Colds  
  Diarrhea  
  Constipation  
  Gas Pains  
  Rashes/Eczema  
  Milk/Lactose Intolerance  
  Food sensitivities  
  Allergies  
  Asthma  
  Headaches  
  Learning Disorder  
  Poor Posture  
  Chicken Pox  
  Pneumonia  
  Whooping Cough (Pertussis)  
  Measles  
  Flu  
  Diabetes  
  Cancer, Leukemia  
  Back pain  
  Neck pain  
  Autism/Autistic spectrum disorder  
  Weight trouble/overweight  
  Other

**KHOURY CENTRE POLICIES:**

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education.

It is our policy that payments for all services are due at the time they are rendered and are not billed periodically to patients. Billing for patients' personal balances increases offices expenses resulting in higher costs of services. We accept cash, personal checks, and most credit cards.

As a courtesy to you we will bill your insurance company for their portion of the bill. All patients are expected to supply this office, in a timely manner, with any and all information necessary to file and bill your claims. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

It is understood and agreed that the amount paid to the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Although unlikely, some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my child's condition, as he or she deems appropriate.

Parent/Guardian's signature: \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO TREATMENT OF MINOR  
(CHILD UNDER 18)**

I hereby request and authorize the doctor(s) of The Khoury Centre to perform diagnostic tests and render chiropractic adjustments and other treatments as necessary to my child, the said patient.

This authorization also extends to all other doctors and trained office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_