

PATIENT INFORMATION (Please Print in Ink)

If you have any questions or concerns do not hesitate to ask/call for assistance, we will be happy to help you.

Name _____ Date of Birth ____ / ____ / ____ Age _____ Female Male
 Address _____ Unit _____ City _____ State _____ Zip _____
 Best Phone # _____ Email (appointment reminders) _____
 Height _____ Weight _____ Occupation _____ Date Symptoms Began _____
 Are you: Minor Married Divorced Widowed Single Separated
 Emergency Contact _____ Emergency Contact Phone # _____
 How did you find us? Google Yelp Walk-In Groupon Insurance Provider List Referred By: _____

INSURANCE INFORMATION

Primary - please present card to front desk

Insurance _____ Primary Insured Name _____ Relation to You _____
 ID/Policy # _____ Group # _____

Secondary - please present card to front desk

Insurance _____ Primary Insured Name _____ Relation to You _____
 ID/Policy # _____ Group # _____

CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and muscle soreness. The scientific literature suggests that serious events such as stroke are rare and that chiropractic is safe.

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including diagnosis, records, treatment and examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to directly pay the chiropractor for chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered to me or my dependents.

X _____ / ____ / ____
 Signature of Patient (or parent if a minor) Date

FINANCIAL RESPONSIBILITY

Payment for services is due at the time services are rendered unless other arrangements have been approved in advance by our staff. If you have a co-pay, we will accept that until we have received notice or payment from your insurance company. Your claims will be filed by us as a courtesy. You realize that your insurance is an agreement between you and your insurance company.

Our fees normally fall with the UCR which is defined as the usual, customary, and reasonable charges for this region. Not all insurance plans will pay for all services performed at this office. Any unpaid balance not paid by insurance is the patient's responsibility. I fully understand this agreement between this office and myself. I am ultimately responsible for the balance of my account for any services rendered.

X _____ / ____ / ____
 Signature of Patient (or parent if a minor) Date

INFANT/CHILD HEALTH HISTORY REVIEW – CONFIDENTIAL

Name: _____ Date: _____ Sex: _____ Birthdate: _____

Birthplace: _____ First/last name of each Parent: _____

Home address of child and each parent: _____

_____ City: _____ State: _____ Zip: _____

Phone # of each parent: _____

Email: _____

Weight: _____ Height: _____ Siblings: _____

Medical Physician/Pediatrician: _____

How did you hear about our office: _____

PRE-NATAL/NATAL HISTORY:

Name of Midwife/Obstetrician: _____

Mother's health status before and during pregnancy: _____

Mother's age at birth: _____ Prior pregnancies?: _____ Miscarriages?: _____

Were any drugs used before or during pregnancy?: _____

Ultrasounds during pregnancy?: Yes _____ No _____ Hospital Birth?: Yes ___ No ___

Were there any known complications at birth for mother or child? Yes _____ No _____

Term of the child at birth (e.g., full term or premature)?: _____

Duration of labor and delivery: _____ Difficult labor/delivery?: _____

Spontaneous or induced labor? _____ Vaginal or caesarean delivery? _____

If caesarean – planned or emergency?: _____

Circle if your child was at any time after the 7th month in an in-utero constrained posture:

Breech Transverse lie (side lying) Face/Brow Presentation

Please circle any item that applies to this child regarding the time during/after delivery:

- a) fetal monitor used b) forceps, vacuum extraction or other instruments used
- c) medications d) breathing problems e) choking f) jaundice
- g) surgery h) artificial feeding i) silver nitrate j) vitamin K
- k) circumcision l) blue baby (cyanosis) m) anemia n) convulsions
- o) infections p) congenital anomalies

Weight at birth: _____ Length at birth: _____ Child's APGAR scores? _____

FEEDING HISTORY:

Breast Fed?: Yes _____ No _____ If yes, how many months? _____ Difficulty Feeding? _____

Formula Fed?: Yes _____ No _____ If yes, Type? _____ Supplements? _____

Introduced to solids at _____ months. Cow's milk at _____ months.

Food sensitivities: _____

MEDICAL INTERVENTIONS:

Vaccinations (if any) received to date: _____

Any surgeries? Yes _____ No _____ If yes, explain: _____

Any medications: Yes _____ No _____ If yes, what: _____

Medical Treatment in last 12 months?: Yes _____ No _____ If yes, what: _____

Number of doses of antibiotics taken during the past 6 months _____, lifetime doses _____

GROWTH AND DEVELOPMENT:

age held head up _____ (1-2 mo) age sat with support (head steady) _____ (3-5 mo)

age rolled from front to back _____ (3-5 mo) age sat alone _____ (9-11 mo)

stood with support _____ (6-8 mo) age walked with support _____ (9-11 mo)

age said first word _____ (12 mo) age when points to desired objects _____ (12 mo)

age walked without support _____ (11.5 mo) age at first tooth _____

Has your child ever fallen from a high place (bed, change table, stairs, etc.)? Yes ___ No ___

Is/was your child involved in any contact sports? Yes ___ No ___

Has your child ever been in a car accident? Yes ___ No ___

Has your child ever been seen on an emergency basis? Yes ___ No ___

Please describe your child's experience with the following:

What hours will your child sleep on a usual day/night? _____

Toileting: _____

Speech: _____

Habits: _____

Discipline: _____

Schooling (day care, nursery): _____

Personality (independence, relationship with parents, siblings and peers, activities and interests): _____

SYSTEM REVIEW OF THE INFANT/CHILD:	Please answer-	YES	NO
1. Has you child experienced weight changes, low energy or recent fever?	_____	_____	_____
2. Skin: Any skin trouble such as rashes, bleeding, dryness, lumps?	_____	_____	_____
3. Head: Any headaches, head injuries, dizziness or balance problems?	_____	_____	_____
4. Eyes: Vision disorders, pain, redness, excessive tearing or glasses/contacts?	_____	_____	_____
5. Ears: Any hearing disorders, infections, ringing in ears or discharge?	_____	_____	_____
6. Nose and sinuses: Frequent colds, nasal stuffiness, sinus trouble or drainage?	_____	_____	_____
7. Mouth and throat: Sore throat, dental trouble, speech trouble or sore tongue?	_____	_____	_____
8. Lymphatics: Enlarged and/or painful lymph nodes?	_____	_____	_____
9. Neck: Lumps/masses, pain, or swollen glands?	_____	_____	_____
10. Breasts: Pain, discharge, masses or asymmetry?	_____	_____	_____
11. Respiratory: Cough, difficulty breathing, frequent colds, allergies or asthma?	_____	_____	_____
12. Cardiovascular: Heart problems, high blood pressure, chest pain or blue baby?	_____	_____	_____
13. Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation, colic, food intolerance, bladder problems, or jaundice?	_____	_____	_____
14. Urinary: Pain, increased frequency of urination, infections or blood in urine?	_____	_____	_____
15. Reproductive: Infections, pain, swelling, testicular masses, painful menses bed wetting, or sexually transmitted diseases?	_____	_____	_____
16. Musculoskeletal: Joint pain, swelling, back pain, neck pain, bone or muscle pain, sports injuries, arthritis, problems walking or scoliosis?	_____	_____	_____
17. Neuological: Fainting, blackouts, seizures, weakness, numbness, tingling, memory problems, abnormal movements or delayed development?	_____	_____	_____
18. Psychological: Depression, poor memory, nervousness or poor thinking?	_____	_____	_____
19. Endocrine: Thyroid problems, excessive sweating or diabetes?	_____	_____	_____
20. Hematologic: Anemia, bruising, bleeding or transfusions?	_____	_____	_____
21. Has your child ever broken a bone?	_____	_____	_____

FAMILY HEALTH HISTORY:

Check if any apply to the child, parents, grandparents or siblings of the child:

Cancer Diabetes Scoliosis Stroke Kidney disease
 Heart trouble Mental illness Nerve disorder High Blood Pressure
 AIDS Anemia Tuberculosis

DATE OF LAST:

Spinal examination _____ Physical examination _____
 Urine test _____ Operation _____
 Hospitalization _____ Illness _____

PURPOSE FOR THIS VISIT:

What is the reason for contacting us? _____

How long has the child experienced this? _____

Is it getting better or worse over time? _____

Have you tried anything for this complaint? _____

Have you seen any other health professionals for this? Yes _____ No _____

Are you content with your child's present level of health? Yes _____ No _____

Are you interested in wellness for your child? Yes _____ No _____

Does your child eat junk food? Yes _____ No _____

Does your child exercise? Yes _____ No _____

INFORMED CONSENT TO CHIROPRACTIC CARE:

You understand that the spinal adjustment is used to correct dysfunctions of the spine involving the joints, muscles and nerves that is called a subluxation.

You consent to the performance of a spinal examination in which the doctor uses their hands to feel the muscles and joints of the back and neck (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for the neck and back, and performs any further orthopedic or neurological tests. X-rays or other imaging may be ordered by the chiropractor.

The tests and spinal adjustments are standard and commonly used. They involve very little risk and serious side effects are rare. Stroke is an extremely rare serious adverse effect associated with cervical (neck) spinal manipulation. The best evidence indicates that cervical manipulation for neck pain is much safer than the use of NSAID's (nonsteroidal anti-inflammatory drugs), by as much as a factor of several hundred times. While no adverse effects are anticipated, the risks are the same as those encountered in a routine visit to any doctor of chiropractic. Some patients may have muscle soreness after chiropractic adjustments or after performing standard physical exam tests.

Spinal adjustments have been used routinely in the management of patients with a variety of symptoms and/or disorders, including those without symptoms who want to improve overall health. Chiropractic is considered part of a wellness lifestyle. I have read and understand this informed consent and I consent to chiropractic examination and care.

Signature of Parent

Date