PATIENT_INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to assist you. (Please Print)

Name _____ Date_____ S/S _____-_____-_____
Address _____City _____State_____Zip _____
Sex Female Male Birth Date ____/____/____Home phone#_____Work # _____
Are you: Minor Married Divorced Widowed Single Separated
Your employer _____Occupation_____
Business Address_____ City _____State _____Zip _____
Spouse or Parent's name _____Workplace _____Work phone_____
Person to contact in case of emergency_____ Phone # _____
Whom may we thank for referring you to us? _____
Email address:_____

INSURANCE_INFORMATION

Primary –*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____
Secondary –*please present card to receptionist.*
Insurance _____ Primary Insured Name _____
Policy #/ SS# _____Date of Birth _____/_____/_____

CHIROPRACTIC_CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 the diagnosis and the records on any treatment or 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 top directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ __/__/____
Signature of Patient (or parent if a minor) Date

FINANCIAL RESPONSIBILITY

Payment for services are due at the time of 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 must realize that your insurance is an agreement between you and your insurance company. We are not part of that contract.

Our fees normally fall within the UCR which is defined as the usual, customary, and reasonable charges for this region. Not all insurances will pay for all services performed at this office. Any unpaid balances 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 professional 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 anomolies

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. Cardiovasular: 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