

Kids Confidential Health Profile (12 and under)

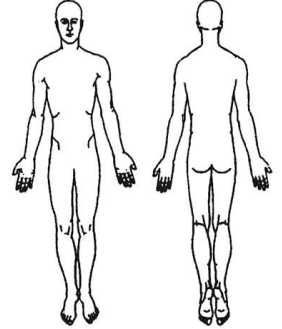
PATIENT INFORMATION (all fields required)

Name: _____ Age: _____ Sex: Male / Female Date of Birth: ____ / ____ / ____
Address: _____ City: _____ State: _____ Zip: _____
Parent's Names: _____ Number of Siblings: _____
First Name & Ages of Siblings: _____
Guardians Phones: Home: _____ Cell: _____ Work: _____ Preferred Phone Number: Home / Cell / Work
For confirming appointments, would you prefer? TEXT / EMAIL If text, who is your cell phone carrier? _____
Email: _____ Who may we thank for referring you? _____

LIST YOUR CHILD'S HEALTH CONCERNS BELOW:

What is your #1 concern? _____ Month & year it started? _____
Have you had it before? Y / N Is it getting better or worse? B / W Is it? [] Constant or [] Come and Go
What has helped it? _____ What makes it worse? _____
Is it? [] Sharp [] Dull [] Achy [] Numb [] Tingling [] Other? _____
Circle how severe is it? (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)
How did it begin? [] Bending [] Lifting [] Twisting [] Fall [] Pushing/Pulling [] Car Accident [] Unknown
[] Other? _____

Put an X at site of symptoms



CIRCLE ALL CURRENT PROBLEMS YOUR CHILD HAS:

☐ Check this box if none

DIZZINESS	GROWING PAINS	CONSTIPATION	NOSEBLEEDS	NERVOUSNESS
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	ADD / ADHD
VERTIGO	ASTHMA	HEARING PROBLEMS	TONSILLITIS	DISC PROBLEM
EAR INFECTIONS	ULCERS	SCIATICA	LIVER PROBLEMS	RECURRENT INFECTIONS
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	DEPRESSION	GASTRIC REFLUX
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	ALLERGIES
NECK PAIN	MENSTRUAL DISORDER	LOW BACK PAIN	ARM PAIN	CHRONIC SINUSITIS
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	SEIZURES
ANXIETY	STOMACH DISORDERS	LEG PAINS	KNEE PAIN	SPINAL BONE FRACTURES
AUTISM	CANCER	EZCEMA	SPINAL SURGERY	OTHER _____
SCOLIOSIS	DIABETES	COLIC	BEDWETTING	_____

Have you seen any other healthcare providers for these conditions? Yes / No *If yes, what type of care, who, and when? _____

List all fractures, surgical operations and the corresponding years: _____

List ALL over the counter & prescription medications and why you are taking them: _____

What type of birth (circle all that apply)? Natural (vaginal with no medications) / Epidural / Forceps / Vacuum Extraction / C-Section

Did your child ever fall from a crib, changing table, or other? If so describe: _____

How many car accidents has your child been in and if applicable, when was the last? _____

What sports or other physical activities does your child engage in (snow sports, football, gymnastics, soccer, karate, etc)? _____

Any falls/accidents to note (at a playground, off a swing, off a horse, on a ball field, etc)? _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, the severity or cause of my health concern. If the patient is a child, please write the child's name here: _____

Patient Signature (or guardian if applicable): _____

Date: _____

FAMILY HEALTH HISTORY

SOME HEALTH PROBLEMS COMMONLY OCCUR IN MULTIPLE MEMBERS OF THE SAME FAMILY. THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING A COMPREHENSIVE REVIEW OF YOUR FAMILY'S CURRENT AND PAST HEALTH HISTORY.

DATE

PLEASE PRINT YOUR NAME HERE

CONDITION	MOM	DAD	BROTHER(S)	SISTER(S)
ARM PAIN				
ARTHRITIS				
ASTHMA				
ADD/ADHD				
ALLERGIES				
BACK TROUBLE				
BED WETTING				
CANCER				
CARPAL TUNNEL				
DECEASED				
DIABETES				
DIGESTIVE PROBLEMS				
DISC PROBLEMS				
EAR INFECTIONS				
FIBROMYALGIA				
HEADACHES				
HEARTBURN				
HIGH BLOOD PRESSURE				
HIP PAIN				
LEG PAIN				
MENSTRUAL DISORDER				
MIGRAINES				
NECK PAIN				
SCOLIOSIS				
SHOULDER PAIN				
SINUS TROUBLE				
THYROID PROBLEMS				
TMJ				
*NOT ABOVE (LIST BELOW)				

INSURANCE INFORMATION *(NO CHARGES WILL OCCUR WITHOUT YOUR PERMISSION)

PRIMARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

IF APPLICABLE:

SECONDARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

- Consultation- includes practice member history. This service is complimentary.
- Assessment/Evaluation (new or established practice member)- includes one or more of the following: range of motion, motion and/or static palpation, leg check, functional assessment, and orthopedic exam. \$100 maximum.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand/instrument. \$40 maximum.
- X-rays- Specific x-ray views will be taken if necessary to evaluate the current state of your spine. These can also be used to indicate progress after a period of care. \$56 per series maximum.

Release of Authorization/Assignment of Benefits & Notice of Privacy Practices Acknowledgement

I understand that I may receive a statement of services received and paid for to submit to my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Terms of Acceptance & Consent to Care

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes (dysafferentation).
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. SOME HAVE BEEN TOLD THERE IS A RISK OF STROKE; HOWEVER, RESEARCH SHOWS YOU ARE JUST AS LIKELY TO HAVE A STROKE LEAVING A MEDICAL DOCTOR'S OFFICE. NECK ADJUSTMENTS HAVE BEEN SHOWN TO PUT NO MORE STRESS ON THE VERTEBRAL ARTERY THAN WHEN YOU ROTATE YOUR HEAD TO ONE SIDE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

By my signature below, I have read and fully understand the above statements: the release of benefits, notice of privacy practices, terms of acceptance, and the consent to care. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Patient Name (printed)

Signature (if applicable of guardian)

Date