CHIROPRACTIC INTAKE & HISTORY (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 and Ages: _____
Father's Occupation: _____ Mother's Occupation:_____
Guardian's Phones: Home: _____ Cell: _____ Work: _____ Preferred Phone Number: Home / Cell / Work
Email: _____ Who may we thank for referring you? _____

HOW CAN WE HELP YOUR CHILD?

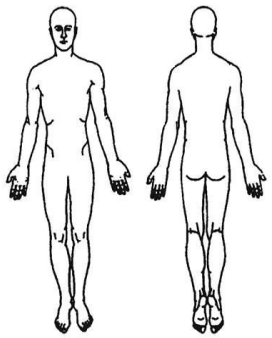
☐ Wellness Checkup ☐ Other: _____

If your child is already experiencing symptoms, please describe it and answer the questions below:

_____

_____

Put an X at site of symptoms



What is your **#1 concern**? _____ Month & year it started? _____
Have they had it before? Y / N Is it getting better, worse or same? B / W / S 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) Do symptoms radiate? Y / N
How did it begin? [ ] Bending [ ] Lifting [ ] Twisting [ ] Fall [ ] Pushing/Pulling [ ] Car Accident [ ] Unknown
[ ] Other? _____

HAS YOUR CHILD EVER SUFFERED FROM (circle all that apply)?:

Allergies	*Broken Bones*	*Digestive Issues*	*Hypertension*	*Orthopedic Problems*
Anemia	*Chronic Ear Infections*	*Dizziness*	*Juvenile / Rheumatoid Arthritis*	*Paralysis*
Arm Problems	*Colds/Flu*	*Fainting*	*Joint Problems*	*Poor Appetite*
Asthma	*Colic*	*Headaches*	*Leg Problems*	*Ruptures/Hernias*
Back Aches	*Convulsions/Seizures*	*Heart Trouble*	*Neck Problems*	*Sinus Trouble*
Wetting	*Delayed Speech*	*Hyperactivity*	*Neuritis*	*OTHER* _____
Behavioral Problems	*Diabetes*	*Tuberculosis*	*Walking Problems*	_____

Has your child seen any other healthcare providers for these conditions? Yes / No *If yes, what type of care, who, and when? _____
_____
List all fractures, surgical operations, hospitalizations and the corresponding years:_____
_____
List ALL supplements, over the counter & prescription/homeopathic 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)? _____
_____

Patient's Signature (or guardians if applicable): _____ **Date:** _____

INSURANCE INFORMATION

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 patient history. This service is complimentary.
- Assessment/Evaluation (new or established patient)- includes one or more of the following: thermography, range of motion, motion and/or static palpation, leg check. $25-$104.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand/instrument. $20-$60.
- 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. $30-80 per series.

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 he 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.
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. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though 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 EXTREMELY RARE, FRACTURES OR BLOOD VESSEL INJURY.

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**