About the Child

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Gender: _____

About the Parent

Name: _____

Marital Status: _____

Insured Date of Birth: _____

Preferred Phone Number: _____

Alternative Phone Number: _____

Email: _____

◯ I authorize correspondence via email and/or texts for appointments, receipts, and other communication even though these modes are not HIPAA compliant.

How did you hear about our office?

_____

Prenatal History

Was your child pre-mature? Y / N

Type of birth: Vaginal Breech delivery

Planned cesarean Emergency cesarean Other

Location of birth: Home Birth Center

Hospital Other

Provider: Midwife OBGYN Other

Any birth trauma: Vacuum extraction Forceps

Fractures Twisting/pulling Other

Do you/did you breastfeed your child? Y / N

If no, which formula is/was utilized? _____

With breast or bottle feeding, please explain if your child does/did prefer either side or any position when feeding? _____

Purpose of Care

What brings your child in today?

_____

_____

When did it begin?

_____

How did it start?

_____

Is it getting worse? Y / N

What is the nature of the discomfort?

Aching Stiff Sharp Shooting Tingling Burning

What percentage of the day does it occur?

0-25% 25-50% 50-75% 75-100%

If old enough, have your child rate his/her discomfort:

Least 0 1 2 3 4 5 6 7 8 9 10 Most

If not old enough, to what degree do you feel his/her symptoms affect your child?

Mildly Moderately Severely

Does the condition interfere with any of the following:

School Sleep Sports Daily routine

What makes symptoms better?

_____

What makes symptoms worse?

_____

Has this occurred before? Y / N

List any other care your child has received in regards to the complaint: _____

Please share other relevant information about the condition:

_____

_____

ABC FAMILY CHIROPRACTIC

Health History

Please list any allergies:

_____

_____

Please list any surgeries:

_____

_____

Please list any current or previous medications & supplements:

_____

_____

Has your child seen a chiropractor before? Y / N

If yes, how long ago: _____

Has your child had x-ray/MRI of the spine? Y / N

If yes, how long ago: _____

Does your child have regular medical care? Y / N

If yes, where: _____

Has your child been immunized according to the recommended schedule? Y / N

Has your child ever suffered any spinal trauma? Y / N (i.e. fall from crib/bed/stairs/playground equipment, car accident, sports injury, etc.)

If yes, please explain: _____

_____

Please circle & mark age where applicable if your child has experienced/been diagnosed with the following:

Anxiety	Asthma	Bedwetting
Blood disorder	Broken bones	Chicken pox
Colic	Concussion	Constipation
Diabetes	Earache	Ear tubes
Extremity pain	Frequent colds	Frequent diarrhea
Growing pains	Headaches	Heart trouble
Hernia	Hyperactivity	Joint problems
Scoliosis	Seizure	Sleeping problems
Skin problems	Torticollis	Vision problems

Family History

Please indicate any pertinent family history of the following conditions:

(P=parent, GP=grandparent, O=other relative)

Arthritis	P	GP	O
Autoimmune condition	P	GP	O
Cancer	P	GP	O
Diabetes	P	GP	O
GI disorder	P	GP	O
Headache/Migraine	P	GP	O
Heart disease	P	GP	O
High blood pressure	P	GP	O
Mental illness	P	GP	O
Neurological disorder	P	GP	O
Osteoporosis	P	GP	O
Stroke	P	GP	O
Scoliosis	P	GP	O

Other

If any, what sports does your child play?

_____

_____

How would you rate your child's diet? (circle one)

Well balanced Average Poor

Is your child on dietary restrictions? Y / N

If yes, please explain: _____

_____

Please share other questions or concern about your child needing to be addressed:

_____

_____

_____

Please circle health goals you hope for your child to achieve through chiropractic care:

Better concentration	Better coordination
Better posture	Better sleep
Easier breathing	Enhanced sports performance
Improved nutrition	Improved overall health
Medication reduction	Relief of current symptoms

NEW PATIENT PAPERWORK

PATIENT NAME: _____ DOB: _____

Please read thoroughly, initial at each applicable section and sign the bottom. Thank you!

Information about possible risk of chiropractic treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you can make an informed decision about whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. As with any health procedure, complications may arise during treatment. These complications include but are not limited to soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are rare occurrences. Doctors of chiropractic, medical doctors, and physical therapists using manual therapy treatment for patients with headaches and cervical spine complaints are required to explain that there may be rare cases of injury to the vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have questions about this, please do not hesitate to speak with your practitioner. If you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

Consent for treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I have weighed the risks involved and decided that it is in my best interest to undergo the treatment recommended.

NON-HIPAA Communication

_____ I understand when I contact the office through social media or email, I am waiving my HIPAA rights as there can be no guarantee that my information can maintain confidential through these routes of communication.

Guarantee of payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of ABC Family Chiropractic. I authorize the facility to release all information necessary to secure the payment of benefits. If my care is not covered through my insurance carrier, I understand that I hold personal financial obligation for payment.

_____

Guardian's Signature **Date** **Relationship to Patient**

Consent to treat a minor

_____ I hereby request and authorize the doctors at ABC Family Chiropractic to perform diagnostic tests, render chiropractic adjustments and perform adjunctive therapies deemed necessary to my minor son/daughter. As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation, or other condition, 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 anyway, I will immediately notify ABC Family Chiropractic.

_____

Guardian's Signature **Date** **Relationship to Patient**

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your healthcare information.

- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have the right to receive a copy of this notice.

_____ _____

Printed Patient's Name **Printed Guardian's Name**

_____

Guardian's Signature **Date** **Relationship to Patient**