CHESTER FAMILY CHIROPRACTIC CENTER

4700 Buckingham Court
Chester, Virginia 23831
804.796.3221
www.ChesterChiropractic.com

Patient Information:

Child's Name: ______________________ Date: ____________

Parents'/Guardians' Name(s): ______________________

Home Address: ______________________

Home Phone: ______________ Do both parents reside at home? ☐ Yes ☐ No

Parent Cell Phone: ______________ Parent Work Phone: ______________

Parent Cell Phone: ______________ Parent Work Phone: ______________

Parent's Email: ______________________

How did you hear about us? ______________________

Height (of child): ______ Weight: ______ Birth Date: ______ Age: ____ Sex: ____

Siblings & ages: ______________________

Emergency Contact:

Name: ______________ Relationship to child: ______________

Phone Number: ______________ Alternative Number: ______________

Family Doctor:

Name: ______________ Professional Designation: ______________

Clinic Name: ______________ Date and reason of last visit: ______________

May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals:

(Medical Specialist, Naturopathic Doctor, Homeopathic, Physiotherapist, OT, Massage Therapist, etc.)

Name: ______________ Profession Designation: ______________

Clinic Name: ______________ Date and reason of last visit: ______________

Name: ______________ Profession Designation: ______________

Clinic Name: ______________ Date and reason of last visit: ______________

Why have you decided to have your child evaluated by a Chiropractor?

☐ He /She is continuing ongoing care from another chiropractor.
☐ I recently had my spine checked and understand the value in getting my child checked.
☐ I have concerns about his/her health and I'm looking for answers.
☐ He /She has a specific condition and I've learned that chiropractic may be able to help.
☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *vertebrae*. Many of the common health challenges that adults experience have their origins during the ***developmental years***, some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins, and emotional stress***. The result may be misalignment to the spinal column and damage to the nervous system - a condition called ***Vertebral Subluxation***. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal***.

What signals has your child's body been communicating?

CURRENT	PREVIOUS	
☐	☐	Asthma
☐	☐	Respiratory Tract Infections
☐	☐	Sinus Problems
☐	☐	Ear Infections
☐	☐	Tonsillitis
☐	☐	Strep Throat
☐	☐	Frequent Colds / Croup
☐	☐	Recurrent Fevers
☐	☐	Eczema
☐	☐	Rashes
☐	☐	Allergies
☐	☐	Food Sensitivities
☐	☐	Digestive Problems

CURRENT	PREVIOUS	
☐	☐	Frequent Diarrhea
☐	☐	Constipation
☐	☐	Flatulence
☐	☐	Headaches/Migraines
☐	☐	Neck Pain
☐	☐	Torticollis / Head Tilt
☐	☐	Trouble Feeding on One Side
☐	☐	Back Pain
☐	☐	Growing Pains
☐	☐	Scoliosis
☐	☐	Red, Swollen, Painful Joint
☐	☐	Colic
☐	☐	Frequent Crying Spells

CURRENT	PREVIOUS	
☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Slow or Absent Reflexes
☐	☐	Asymmetrical Crawling or Gait
☐	☐	Weight Challenges
☐	☐	Bed Wetting
☐	☐	Sleep Problems
☐	☐	Night Terrors
☐	☐	Tip Toe Walking
☐	☐	Sensory Processing Issues
☐	☐	Seizures
☐	☐	Tremors / Shaking
☐	☐	ADD / ADHD
☐	☐	Autism / PPD

Do you have a specific concern that brings you in?

☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.

☐ Yes: ______________________________

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? __________ For how long? ______________

Is it getting better, worse, or staying the same? ______________ Suddenly or gradually? ____________

Have you seen other health professionals regarding this complaint?

☐No ☐ if Yes, whom? ______________________________

What treatment did they use? ______________________________

Has your child taken any medication for this complaint? ☐ No ☐ Yes: ______________

Has your child ever experienced this complaint before? ☐ No ☐ Yes: ______________

Has your child received any treatment at this time? ☐ No ☐ Yes: ______________

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: ______________

Has your child had any blood work done for the current complaint? ☐ No ☐ Yes: ______________

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (brief description): ____________________

Ultrasounds during pregnancy: ☐ No ☐ Yes (brief description): ____________________

Medications during pregnancy: ☐ No ☐ Yes (brief description): ____________________

If so which ones and how often? (include OTC):

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐ No ☐ Yes (brief description): ____________________

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: ____________

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other: ____________

Medications during labor / delivery (including IV antibiotics): ☐ No ☐ Yes: ____________

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? ________ If C-section, was it planned or emergency? ________

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: ____________________

How long was the labor from the first regular contractions to the birth? ____________ hours.

How long was the second stage (the pushing phase) of the labor? ____________ hours.

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? __________ Weight: ________ Length: ________

If known, APGAR scores at: 1 minute: _______/10 5 minutes: _______/10

Was the baby ever administered to the NICU? ☐ No ☐ Yes

If yes, for how long and why? ____________________

Was any medication given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? ____________________

Was your child exclusively breastfed? ☐ No ☐ Yes Months: __________

Was your child breastfed + formula fed? ☐ No ☐ Yes Months: __________

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

What age did you introduce solid foods to your child? __________ months

Did you introduce cereal or grains within your child's first year? ☐ No ☐ Yes

Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc)?

☐ No ☐ Yes Which ones? ____________________

Physical Traumas

Has your child ever fallen from any high places? ☐No ☐Yes ______________

Has your child ever been involved in a motor vehicle accident? ☐No ☐Yes ______________

Has your child been seen on an emergency basis? ☐No ☐Yes ______________

Has your child broken any bones? ☐No ☐Yes ______________

Has your child had any previous hospitalizations? ☐No ☐Yes ______________

Has your child had any previous surgeries? ☐No ☐Yes ______________

Does your child use a tablet, computer, or video game? ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child watch TV? ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child exercise? ☐No ☐Daily ☐Weekly ☐Seasonally

Does your child play contact sports? ☐No ☐Daily ☐Weekly ☐Seasonally

Does your child sleep on their... ☐Back ☐Belly ☐ Sides (both, right, left)

Does your child carry a back pack? ☐No ☐ Yes

Does it weigh less than 15% of their body weight? ☐No ☐ Yes

Do they wear their back pack on 2 shoulders? ☐No ☐ Yes

Does your child show excessive or uneven shoe wearing out? ☐No ☐ Yes

Does your child wear custom orthotics?

☐No ☐Yes, For what purpose? ______________________________

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed schedule ☐Yes, on schedule

Reason for vaccination: ☐ Personal research ☐Didn't know I had a choice ☐It was recommended

Reaction(s) to vaccination: ☐ None ☐Fever ☐Diarrhea ☐Rash ☐ Welt at injection site
☐ Fatigue ☐Seizures ☐Prolonged Cry ☐Developmental Regression
☐Other: ______________________________

Does your child receive annual flu shots? ☐No ☐Yes (personal research) ☐Yes (MD recommended)

Has your child been exposed to antibiotics? ☐No ☐Yes

If yes, how many doses in past 6 months? _____ Reason: ______________

Has your child been exposed to medications, including OTC?

If yes, which ones? ______________________________

If yes, how many doses in past 6 months? _____ Reason: ______________

How many glasses of water/day does your child have? ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+

How many glasses of cow's milk, juice, and soda/day? ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+

Does your child eat gluten? ☐No ☐ Yes ☐ Trying to eliminate

Does your child eat dairy? ☐No ☐ Yes ☐ Trying to eliminate

Any food/drink allergies or sensitivities? ☐No ☐Yes ______________

Is your child exposed to second hand smoke? ☐No ☐Yes ______________

Does your child take a probiotic daily? ☐No ☐ Yes __________ CFU's/day

Does your child take a vitamin D3 daily? ☐No ☐ Yes __________ IU's/day

Does your child take Omega 3 Fish Oils daily? ☐No ☐ Yes __________ mg/day

Other supplements or homeopathics? ______________________________

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No ______________________________

Emotionally: ☐ Yes ☐ No ______________________________

Physically: ☐ Yes ☐ No ______________________________

What is your primary goal for your child at our clinic? ______________________________

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I, ______________________ *(print name of consenting adult)*, being the parent or legal guardian of ______________________ *(print name of minor)*, hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

______________________________ ______________________________

Consenting Adult's Signature Date

Patient Consent Form

Regarding the Use and Disclosure of Protected Health Information

For the purpose of this Consent Form, "Office" shall refer to Chester Family Chiropractic Center.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy entitled "Our Privacy Practices". I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice revised, I can call the Office to request a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in, but only to the extent that the office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in my writing.

Your signature also allows us to discuss or release any medical/financial information to the person(s) you choose to authorize below.

Patient name (Please Print)____

Signature____

Date___/___/_____

Authorization to (Please Print) ____

Relationship____

Date___/___/_____ Revoked Date___/___/_____

Authorization to (Please Print) ____

Relationship____

Date___/___/_____ Revoked Date___/___/_____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien is made by and between ______________________(Patient) and Chester Family Chiropractic Center. With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including 2% interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, 2% interest, collection costs and attorney's fees of 40%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged: ________(patient initials)

Witness the following signatures and seal as of the indicated date:

Patients Signature ______________________________________

Printed Name_______________________ Date____/____/_____

SSN #__________________

Witness___________________________ Date____/____/_____

Health Care Provider

Chester Family Chiropractic Center

By:

It's Owner

Date ____/____/_____