WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

PATIENT NAME

DATE COMPLETED
Patient Information

Name: ____________________________ (Age) ________ Gender: M F

Home Address: ____________________________________________ Birth Date: ______ / ______ / ______

City, State, Zip: ____________________________________________ Cell Phone: ( ) ________________________

Name of Mother/Guardian: ____________________________________ Home Phone: ( ) ________________________

Birth Date: ______ / ______ / ______ (Age) ________ Marital Status: S M D W

Home Address (if different): ____________________________________ Work Phone: ( ) ________________________

City, State, Zip: ____________________________________________ Cell Phone: ( ) ________________________

Employer Name: ____________________________________________ Email: _______________________________

Name of Father/Guardian: ____________________________________ Home Phone: ( ) ________________________

Birth Date: ______ / ______ / ______ (Age) ________ Marital Status: S M D W

Home Address (if different): ____________________________________ Work Phone: ( ) ________________________

City, State, Zip: ____________________________________________ Cell Phone: ( ) ________________________

Employer Name: ____________________________________________ Email: _______________________________

Employer Name: ____________________________________________ Occupation: ____________________________

How were you referred to this office? ________________________________________________

Purpose For This Visit

Reason for this visit: ____________________________

Is this related to an accident or specific injury (other than auto or work-related)? Y N

If yes, when: ______ / ______ / ______

*If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms: ____________________________________________

Please use the General Symptoms Chart on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin? ______ / ______ / ______ Are they: Y N Constant Y N Intermittent Y N Activity-related

Are they getting worse? Y N Do they interfere with: Y N School Y N Sleep Y N Hobbies/Play Y N Daily Routine

Explain: ____________________________________________

What activities aggravate these symptoms?

Is there anything that relieves your symptoms? Y N If yes, explain: ____________________________

Has your child experienced these symptoms before (if not accident/injury related)? Y N

If yes, explain: ____________________________________________

Has your child been treated for this? Y N

When was the last treatment? ______ / ______ / ______

Name of treating practitioner/facility: ____________________________

What treatment(s) was performed? ____________________________________________

How did your child respond? ____________________________________________
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child’s symptoms, as it relates to the purpose of your visit today.

A = ACHE       G = STABBING
B = BURNING    M = SPASMS
P = PINS & NEEDLES  F = STIFFNESS
N = NUMBNESS  T = TINGLING
O = OTHER

FRONT

BACK

If you marked “O” for Other on any part, please explain below:
Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your child’s condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (if you check an item with an asterisk, please offer a detailed explanation):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma*
- Rough shaking as an infant
- Were involved in a car accident (if you check this item, please ask the front desk person for the corresponding form)
- Experience broken bones or debilitating injuries*
- Difficult Birth (see below)

Explanation of (*) item(s):

BIRTH EXPERIENCE:

How long was labor?________________________

Describe any complications:_____________________

Type of delivery:  
- Vaginal
- C-Section
- Vacuum Extraction
- Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. ____________________________ Age: ___  Mos.  ___ Yrs.  Where received:________________________________________________________________________

2. ____________________________ Age: ___  Mos.  ___ Yrs.  Where received:________________________________________________________________________

3. ____________________________ Age: ___  Mos.  ___ Yrs.  Where received:________________________________________________________________________

4. ____________________________ Age: ___  Mos.  ___ Yrs.  Where received:________________________________________________________________________

5. ____________________________ Age: ___  Mos.  ___ Yrs.  Where received:________________________________________________________________________

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

- Swelling, redness, heat/hardness of site
- Body rash or hives
- High fever (over 103 degrees)
- High-pitched screaming
- Extreme sleepiness or unresponsiveness
- Body twitching or paralysis
- Breathing problems (asthma, etc.)
- Excessive bleeding or anemia
- Head banging
- Excessive diarrhea or chronic constipation
- Loss of memory/foggy state
- Muscle weakness
- Chronic ear or respiratory Infections
- Vision or hearing disturbances
- Joint pain
- Crossing of eyes
- Seizures
- Other (please explain)

Explanation(s):

Health Conditions continued...

CERVICAL SPINE (NECK)
Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.

- Neck Pain
- Pain in shoulders/arms/hands
- Numbness/tingling in arms/hands
- Hearing disturbances
- Weakness in grip
- Colic
- Sore throats
- Auto-Immune Diseases
- Headaches
- Dizziness
- Visual disturbances
- Coldness in hands
- Thyroid conditions
- Ear Infections
- Learning disabilities
- Other (please explain)
- Sinusitis
- Allergies/Hay fever
- Recurrent colds/Flu
- Low Energy/Fatigue
- TMJ/Pain/Clicking
- Flu/Stomach disorders
- Hyperactivity/ADD

Explanation(s): ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

THORACIC SPINE (UPPER BACK)
Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.

- Heart Palpitations
- Heart Murmurs
- Shingles
- Shortness Of Breath
- Upper Back Pain
- Pain On Deep Inspiration/Expiration
- Recurrent Lung Infections/Bronchitis/Pneumonia
- Asthma/Wheezing
- Tachycardia (fast heart beat)
- Other (please explain)

Explanation(s): ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

THORACIC SPINE (MID BACK)
Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.

- Mid Back Pain
- Pain in ribs/Chest
- Indigestion/Heartburn
- Liver problems
- Tired/Irritable after eating or when not having eaten for a while
- Nausea
- Ulcers/Gastritis
- Reflux
- Spleen problems
- Diabetes
- Hypoglycemia
- Other (please explain)

Explanation(s): ____________________________________________________________

________________________________________________________________________

________________________________________________________________________
Health Conditions continued...

LUMBAR SPINE (LOW BACK)
Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.

- Pain in hips/legs/feet
- Weakness/injuries in hips/knees/ankles
- Low back pain
- Numbness/tingling in your legs/feet
- Recurrent bladder infections
- Coldness in legs/feet
- Frequent/difficulty urinating
- Muscle cramps in legs/feet
- Constipation/Diarrhea
- Menstrual irregularities/cramping (females)
- Other (please explain)

Explanation(s): ________________________________

OTHER

Please list any health conditions not mentioned: _____________________________________________

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): _______________________________________________________

Please list any surgeries (include type of surgery and date it was performed): _______________________________________________________

Family Health History

Have any of your family members ever been diagnosed with the following? If so, please indicate “P” for your child (patient), and “O” for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation):

- ADD
- Arthritis
- Broken bones/fractures
- Circulatory problems
- Ear Infections
- Fetal drug exposure
- Heart disease
- High blood pressure
- Kidney Disease
- Measles
- Neurological problems
- Pneumonia/Bronchitis
- Scoliosis
- Spinal Bifida
- Tuberculosis
- Allergies/Hay fever
- Asthma
- Cancer
- Crohn’s/Colitis
- Eczema
- Food allergies
- Heart murmur
- HIV
- Liver disease
- Metal implants
- Osteoporosis
- Polio
- Seizure disorder
- Stroke
- Varicose veins
- Anemia
- Bed wetting
- Cerebral Palsy
- Depression
- Eczema/Psoriasis
- Gall bladder
- Hepatitis
- Infectious disease
- Lumbago
- Migraine headaches
- Paralysis
- Rash
- Sickle cell anemia
- Thyroid problems
- Whooping cough
- Appendectomy
- Blood sugar problems
- Chicken pox/shingles
- Diabetes
- Epilepsy/seizures
- Headaches
- Hernia
- Influenza
- Lung disease
- Mumps
- Pleurisy
- Rheumatic fever
- Small Pox
- Tonsillectomy
- Other

Explanation of (*) item(s): _____________________________________________
Experience with Chiropractic

Has your child seen a Chiropractor before?  □ Yes □ No  Who?  

Reason for visit(s):  

Did the previous chiropractor take ‘before’ and ‘after’ x-rays? □ Yes □ No  What was the diagnosis?  

Did he or she recommend a specific course of treatment? □ Yes □ No  Did they recommend a Home Health Care program? □ Yes □ No  If yes, what?  

How long was your child treated?  Last treatment:  /  /  

How did your child respond?  

Are you aware of any poor posture habits in your child? □ Yes □ No  Is there any history of spinal problems in your family? □ Yes □ No  If yes, explain:  

Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.  

Date of last menstrual cycle:  /  /  

Guardian Signature  Date  /  /  

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.  

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.  

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.  

I also clearly understand that if I do not follow the doctors and/or staff’s specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.  

Patient’s Signature  Date  /  /  

Patient’s Name Printed  

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:  

Date Guardianship Awarded  County, State of Guardianship  

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.  

Guardian Signature  Date  /  /  

In Case of Emergency

Name  Relationship  

Work Phone ( )  

Home Phone ( )  

Cell Phone ( )
Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor’s office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ☐ Yes ☐ No

Signature of Person Authorizing Care:

_________________________________________ Date _____ / _____ / _____

Relationship to Insured ________________________________ Date of Birth _____ / _____ / _____

Employer _________________________________________

Primary Insurance Company ___________________________ Policy#________________________

Address Phone # (            )_________________________

Insured’s Name ________________________________ Insured’s Social Security #: ______ - ______ - _______

Secondary Insurance Company _________________________ Policy#________________________

Address Phone # (            )_________________________

Insured’s Name ________________________________ Insured’s Social Security #: ______ - ______ - _______