



Confidential Patient Information - Pediatric (3 and Under)

Patient Name: _____ S.S.#: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Home Phone: _____
 Birth Date: ____ / ____ / _____ Work Phone: _____
 Sex: M / F Weight: _____ Height: _____ Referred By: _____
 Name of Parents / Guardians: _____

Purpose For Contacting Us ? _____

Other doctors Seen for this Condition _____ N _____ Y , Doctor's Names and Prior Treatments: _____

Other Health Problems ? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Previous Chiropractor: _____
 Date of Last Visit: __ / __ / ____
 Reason: _____

Name of Pediatrician: _____
 Date of Last Visit: __ / __ / ____
 Reason: _____

Are You Satisfied with the Care Your Child Receives? ___N ___Y

Family Health History							
Condition:	Myself	Spouse	Mom	Dad	Brother	Sister	Other
Age (if living)							
Heart Disease							
Cancer (Type _____)							
Diabetes							
Digestive Complaints							
Neck Pain							
Low Back Pain							
Carpal Tunnel Synd.							
Headaches							
Multiple Joint Pains							

Medications:

Number of Doses of **Antibiotics** Your Child has Taken:
 During the Past Six Months: _____
 Total During His / Her Lifetime: _____

Other Medications Taken in Last Six Months:

Vaccination History:

- My child's vaccinations are up to date My child has not received any vaccinations
 I do not know if my child was vaccinated My child had an adverse reaction to the following vaccine: _____



Prenatal History:

Name of Obstetrician / Midwife: _____
 Complications During Pregnancy? ___N ___Y List: _____
 Ultrasounds During Pregnancy? ___N ___Y, Number: _____
 Medications During Pregnancy / Delivery? ___N ___Y List: _____
 Cigarette / Alcohol Use During Pregnancy? ___N ___Y
 Location of Birth: ___ Hospital ___ Birthing Center ___ Home
 Birth Interventions: ___ Forceps ___ Vacuum Extraction ___ Caesarian Section, Emergency or Planned?
 Complications During Delivery? ___N ___Y, List: _____
 Genetic Disorders or Disabilities? ___N ___Y, List: _____
 Birth Weight _____ Birth Length _____ APGAR Scores _____, _____

Feeding History:

Breast Fed: ___N ___Y, How Long? _____
 Formula Fed: ___N ___Y, How Long? _____, Type: _____
 Introduced to Solids at: _____ Months, Cow's Milk at _____ Months
 Food / Juice Allergies or Intolerances: ___N ___Y, List: _____

Accidents and Traumas:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, ect.). Was this the case with your child? ___N ___Y

Is / Has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, ect.). ___N ___Y, List: _____

Has your child Ever Been Involved in a Car Accident? ___N ___Y, List: _____

Has Your Child Ever Been Seen on an Emergency Basis? ___N ___Y, List: _____

Other Traumas Not Described Above? ___N ___Y List: _____

Prior Surgery: ___N ___Y, List: _____

Menarche: ___N ___Y, Age: _____

Childhood Diseases:

Chicken Pox N / Y, Age _____ Mumps N / Y, Age _____ Rubeola N / Y, Age _____
 Rubella N / Y, Age _____ Whooping Cough N / Y, Age _____ Other N / Y, Age _____

Financial Arrangement:

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our clients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility. The amount of your insurance coverage and the out of pocket expense will be discussed at the DOCTOR'S REPORT on the second visit and convenient payments plans will be made. The doctor will discuss all fees before any services are provided.

I have read and understand the statements above.

Name: _____ Signature: _____ Date: ___/___/___

Authorization For Care of Minor:

I hereby authorize this office and it's doctors to administer care to my child as they deem necessary.

Signed: _____ Witnessed: _____ Date: ___/___/___

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
 YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS**

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

___ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

___ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

___ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

___ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

___ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

___ 7. I give Align Life permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.

___ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

___ 9. This office posts a notice for Patient of the Week. If I receive that designation I authorize Align Life to post my name in the office.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date: _____

Patient's Name (Printed) _____

Patient Name (Signed) _____

Patient DOB: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.healthsolutions.net

I have read and understand the information above.

Print Name: _____ Sign: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

To: Align Life

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Print Name: _____ Sign: _____ Date: _____