# REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Cell Phone _____
Patient Last Name_____ First Name_____ Initial____ Email _____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____
Insured Name_____ how and where did you learn about this clinic? _____
Last Name First Name Initial
Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

| | |
|---|---|
| **EMPLOYER** | Company Name_____ Occupation_____<br>Address_____ Phone_____ ☐ Full-time ☐ Part-time<br>City_____ State_____ Zip_____ Years Employed_____ |
| **SPOUSE (PARENT)** | Name_____ Birth date_____ SSN:_____<br>Last Name First Name Initial<br>Employer Name_____ Years Employed_____<br>Address_____ Phone_____ Occupation_____<br>City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time |
| **PATIENT INSURANCE INFORMATION** | Please list any and all insurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ ID #:_____ |
| **SPOUSE COINSURANCE INFORMATION** | Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ ID #:_____ |
| **MEDICAL AND LEGAL INFORMATION** | Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials:_____<br>If you answered yes, please fill out accident specific form, available at the front desk.<br>Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____<br>Person to contact in an emergency _____<br>Phone_____ Relationship_____<br>I have been given a copy of the HIPPA Notice to keep _____ |
| **PATIENT AGREEMENT** | **LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**<br>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Schwietert Chiropractic Clinic, P.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** *I hereby authorize the doctor to release all medical information necessary to process this claim.* I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.<br>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.<br>Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.<br>This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.<br><br>_____ _____<br>Signature of Insured / Guardian Date |

# SCHWIETERT CHIROPRACTIC CLINIC
## PEDIATRIC PATIENT INTRODUCTION

Child's name: _____
Referred by: _____

Birth date: _____ Age: _____ Sex: _____ Number of siblings: _____
Birth length: _____ Birth weight: _____ Current height: _____ Current weight: _____

Obstetrician/Midwife: _____ Pediatrician/Family MD: _____
Date of last visit: _____ Purpose: _____
Previous Chiropractor: _____
Date of last visit: _____ Purpose: _____
Has your child ever been treated in an emergency situation? □ Yes □ No
Please explain: _____

What are you chief concerns, if any, with your child's health? _____
_____
_____
What is your main reason for contacting us? _____
_____
_____

Date of onset of the complaint: _____
Onset was: □ Sudden □ Gradual □ Associated with an event

Duration of problem or episode: □ Minutes □ Hours □ Days □ Months □ Years

Pattern of problem: □ Constant □ Intermittent □ Occasional □ Cyclical

Initiating factors: _____
Aggravation factors: _____
Relieving factors: _____

How does the problem affect your child's daily activities? _____
_____
Prior occurrences or episodes? _____
Other health concerns? _____
_____

## PEDIATRIC CASE HISTORY

**History of Birth**
Third trimester presentation: □ Vertex □ Breech □ Transvers □ Face/Brow
Duration of gestations: _____ weeks
Location of birth: □ Home □ Birthing center □ Hospital
Type of birth: □ Normal vaginal □ Forceps □ Vacuum section □ Cesarean section
Were mediations given to the mother at birth? □ Yes □ No
If yes, what? _____
_____

# SCHWIETERT CHIROPRACTIC CLINIC

Were there any complications during delivery? □ Yes □ No
If yes, what? _____

_____

Duration of birth: _____ Apgar at birth: _____ Apgar after 5 minutes: _____
Congenital anomalies/defects? □ Yes □ No If yes, please explain: _____

_____

**Growth and Development**
Was the infant alert & responsive within 12 hours of delivery? □ Yes □ No
If no, please explain? _____

_____

Where there any delays of the following milestones: □ Respond to sound □ Follow an object
□ Hold up head □ Vocalize □ Sit alone □ Crawl □ Walk

Normal sleeping patterns? □ Yes □ No If no, please describe: _____

Describe any health problems on the mother's side of the family: _____

_____

Describe any health problems on the father's side of the family: _____

_____

Do the child's siblings have health problems? □ Yes □ No
If yes, please describe: _____

At what age, if ever, did the child suffer from the following childhood diseases?
Chickenpox: _____ Mumps: _____ Measles: _____ Rubella: _____
Rubeola: _____ Whooping cough: _____ Other: _____

**Environmental Stressors**
During pregnancy, did the mother:

1. Smoke: □ Yes □ No
2. Drink: □ Yes □ No
3. Take supplements: □ Yes □ No If yes, what? _____
4. Take drugs: □ Yes □ No If yes, what? _____
5. Become ill: □ Yes □ No
6. Receive a vaccination □ Yes □ No If yes, what? _____
7. Receive an ultrasound □ Yes □ No If yes, how many? _____
8. Receive an invasive procedure (i.e. Amniocentesis, cvs)? □ Yes □ No

Was your child breastfeed? □ Yes □ No If yes, for how long? _____
At which age was formula introduced? _____ Which brand? _____
At which age was cow's milk introduced? _____ Soy milk? _____ Solid foods? _____

Did your child receive vaccinations? □ Yes □ No
If yes, please list: _____
Did your child react to the vaccinations? □ Yes □ No
Has your child been prescribed antibiotics? □ Yes □ No
If yes, how many courses and why? _____
Is the child around pets at home? □ Yes □ No
Are there smokers in the home? □ Yes □ No

# SCHWIETERT CHIROPRACTIC CLINIC

**Mental Stressors**

Any difficulties with lactation? □ Yes □ No Difficulties bonding? □ Yes □ No

Have you noticed any changes in behavior? □ Yes □ No

If yes, please explain:_____

Does your child have difficulty sleeping? □ Yes □ No

Does your child go to daycare? □ Yes □ No If yes, from what age? _____

Average hours of TV/computer per week? _____

**Physical Stressors**

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □Stuck in birth canal
□ Fast or long birth □ Respiratory depression □ Cord around neck □ Other

Any falls/accidents during pregnancy? □ Yes □ No

Has this child ever suffered from:

- □ Headaches
- □ Dizziness
- □ Fainting
- □ Seizures/ Convulsions
- □ Heart trouble
- □ Chronic earaches
- □ Sinus trouble
- □ Asthma
- □ Colds/flu
- □ Colic
- □ Orthopedic problems
- □ Neck problems
- □ Eczema
- □ Loss of consciousness
- □ Urinary tract infections
- □ Hepatitis or jaundice
- □ Arm problems
- □ Leg problems
- □ Joint problems
- □ Backache
- □ Poor posture
- □ Scoliosis
- □ Walking trouble
- □ Broken bones
- □ Digestive disorders
- □ Poor appetite
- □ Stomach aches
- □ Reflux
- □ Constipation
- □ Diarrhea
- □ Diabetes
- □ Hypertension
- □ Anemia
- □ Bed wetting
- □ Behavioral problems
- □ ADD/ADHD
- □ Ruptures/hernia
- □ Muscle pain
- □ Growing pains
- □ Allergies
- □ Vision problems
- □ Hearing problems
- □ Nose bleeds
- □ Other_____

Has the child ever suffered from any major falls/accidents? □ Yes □ No

If yes, please explain:_____

Has the child ever sustained an injury playing organized sports? □ Yes □ No

If yes, please explain: _____

Has the child ever sustained an injury in an auto accident? □ Yes □ No

If yes, please explain: _____

Weight of school backpack: _____

Surgery:_____

Current and past medications: _____

# SCHWIETERT CHIROPRACTIC CLINIC
## INFORMED CONSENT TO TREAT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy and EMS. Physical therapy, massage and exercises may also be used.

**The material risks inherent in chiropractic adjustment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation, extra spinal manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options**

Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Hospitalization
- Surgery
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**
**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

**I have read | | or have had read to me | | the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. James Schwietert and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

**Signature:** _____ **Date:** _____
**(Patient, Parent or Guardian, if minor)**