DR. EMIL A. TOCCI
CHIROPRACTOR

Children's Case History

Child's Name_____Birthdate_____Sex_____
Address_____City_____Zip_____
Parents' Names_____
Parents' Phone #_____Work #_____
Siblings and ages_____
Social Security Number_____
How old is, or was, your oldest living relative? _____ years old.
Who referred you to our office? _____

CAUSE

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones and the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can results in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic? _____Who? _____
   Were x-rays taken? _____ Who is your regular pediatrician? _____

2. Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage, and even death to an infant.
   Did you have ultrasound during this pregnancy? _____Frequency_____
   - Place of birth: Home/ Birthing Center/ Hospital .
   - Provider: Midwife/ OB-Gyn/ Other_____
   - Type of Birth: Vaginal/ C-section. Was anesthesia used?_____Type_____
   - Was labor induced? _____If yes, why? _____

- What position did you deliver in: Squatting/ On back
- Birth trauma: Doctor assisted/ Twisting, Pulling/ Vacuum extraction/ Forceps
- Newborn trauma (medical procedures and tests)_____

3. Did you breast feed your child? _____yes _____no. How long? _____
   Was your decision supported by your health care provider? _____yes _____no.
   Repeated studies are now informing us breast-feeding develops strong and healthy immune neurological and digestive systems.

4. According to the National Safety Council, approx. 50% of infants have fallen onto their heads during the first years of their life. Another study reveals ¼ million children are injured in playgrounds annually. Can you recall any such jolts, falls, or traumas to your child? _____
   Please describe: _____
   Any fractures or dislocations? _____

5. Which sport does your child play? Soccer/ Football/ Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other _____

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? _____ yes _____ no. Is it in front of a computer or TV?

7. How would you rate your child's diet? _____
   Does your child consume artificial sweeteners? _____ Drink water? _____
   How many glasses a day? _____

8. Circle any of the following conditions your child has suffered from : Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other _____

9. How often has your child been treated with drugs? _____
   Were you informed of their adverse reactions? _____yes _____no
   If it was an antibiotic, was your child cultured for its use? _____

10. The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral, emotional, or physical changes within 3 months after any shots? _____ Describe_____
    Was it reported by you or your doctor? _____

INSURANCE INFORMATION: (Please present card to be copied)

What insurance plan do you have?

Is a referral required?

What is your co-payment?

Correction

Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Emil A. Tocci to administer care as deemed necessary to my son/daughter.

Signed_____ Date_____

Witnessed by: _____Date_____

Assignment of benefits

I irrevocably assign to Dr. Emil A. Tocci all my rights and benefits under any insurance contracts for payment services rendered to me by Dr. Emil A. Tocci. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Dr. Emil A. Tocci be released to him. I irrevocably authorize Dr. Emil A. Tocci to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly Dr. Emil A. Tocci I irrevocably authorize Dr. Emil A. Tocci to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect. I understand that I am personally responsible for payment for all services rendered in accordance with the regulations of New York.

_____ _____

Name Date

Parental Consent Form

I, _____, the legal parent/guardian of _____, give permission for my son/daughter to be examined and treated by Dr. Emil A. Tocci.

Sign _____ Date _____

Emil A. Tocci, D.C., CCWP, CCSP, CCN
3089 Lawson Blvd.
Oceanside, N.Y. 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLWDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Private Practices written in plain language.
The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Relationship to patient (if other that self): _____

Date: _____

Terms of Acceptance

When a patient seeks chiropractic health 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. It is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)