Elite Chiropractic Consent Form

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, and any other associated procedures on me by Dr. Scott Nigbor and Associates of Elite Chiropractic.

I understand, as with any other health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, soreness.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgments during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read the above explanation of chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment as Elite Chiropractic. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future treatment I seek.

____ ______________________

Signature of Patient Date

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here-and most importantly, getting results!

Please check the circle that applies to you:

☐ Sure! You can use my pictures as long as I look good in it!

☐ No Thanks! I will pass for now.

____

Printed name of Patient

____

Signature of Patient Date

____

**List family members this applies to as well

Pediatric Patient Questionnaire

Child's Name ____________________ Parent/Guardian Name(s) ____________________

Address: ____________________ City, State, Zip: ____________________

Cell Phone: ____________________ Other Phone: ____________ Child Sex: ________

Email: ____________________ Birth Date: ____________ Age: ________

How did you hear about us? ____________________ Weight: ________ Height ________

Who is your primary care physician? ____________________

Is your child receiving care from any other health professional? Yes No ____________________

-If yes, please list name and specialty ____________________

Please list any drugs/medications/vitamins/herbs that your child is taking; ____________________

CURRENT HEALTH CONDITIONS:

What health condition(s) bring your child in to Elite Chiropractic? ____________________

____

When did this condition begin? ____________________

How did the problem start? (please check one) _____Suddenly _____Gradually _____Post Injury

Has your child been treated for this before?____________________

Is this condition: _____Getting Worse _____Improving ______Constant _____Unsure

What makes the problem better? ____________________ What makes the problem worse? ____________________

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. ____________________
2. ____________________
3. ____________________

What would you like to gain from chiropractic care?

- Resolve existing condition
- Overall wellness
- Both

PLEASE TELL US ABOUT YOUR PREGNANCY

Please circle

Any Fertility issues? Yes No If yes, please explain:

Did mother smoke? Yes No If yes, how many per week?

Did mother drink? Yes No If yes, how many per week?

Did mother exercise? Yes No If yes, please explain:

Was mother ill? Yes No If yes, please explain:

Any ultrasounds? Yes No If yes, please explain:

Any notable episodes of mental/physical health? Yes No

Any other notable concerns about conception/pregnancy? ____________________

LABOR AND DELIVERY

Please circle below:

Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section

Child's birth was: At home Birthing center Hospital Other_______________________________

Circle any that apply below:

Breech Induction Pain Meds Epidural Episiotomy Vacuum Forceps Other

At how many weeks was baby born? ____

Birth weight ______________________________ Birth height ______________________________

GROWTH AND DEVELOPMENT

Is/was your child breastfed? _____Yes _____No If so, how long? _________________ Difficulty? _____________

Did they ever use formula? _____Yes _____No If yes, at what age? ____________ Type _________________

Did/does your child suffer from colic, reflux, or constipation as an infant? _____Yes _____No

Did/does your child frequently arch their neck/back, feel stuff, or bang their head? _____Yes _____No

At what age did the child: Respond to sound? _______ Follow objects: _______ Hold up head: _______

Teethe: _______ Sit alone: _______ Crawl:_______ Walk: _______ Begin cow's milk: _______ Solid Food: _______

List any food intolerance/allergies and when they began: ____

Please list any hospitalization or surgical history and year:

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

____

Have you chosen to vaccinate your child? ______Yes ______No

Has your child received any antibiotics? ______Yes ______No If yes, how many times and reason: ________________

Night terrors or difficulty sleeping? ______Yes ______No Behavioral, social or emotional issues? _______________

If yes, please explain: ____

How many hours a day does your child typic ally spend watching TV, computer, tablet or phone? _____________________

How would you describe your child's diet? (please check one) ______Mostly whole, organic foods ______Pretty average

______High amount of processed foods

ACKNOWLEDGEMENT AND CONSENT

Parent/Guardian Signature ____ **Date:**_______________________

Would you like text reminders? _____Yes _____No

Cell Phone PROVIDER________________________ Cell NUMBER__________________________

_____2 Hours Before _____4 Hours Before _____1 Day Ahead