ProWellness Chiropractic
11876 Olio Rd, Suite 500
Fishers, IN 46038
317-595-9620

Child Case History

Please Print Clearly and Fill In Completely

Personal Information

Name ______ Age ______ Birthdate ______ Sex ______

Address ______ City ______ State ______ ZIP ______

Parent's names ______

Parent's Phone Number ______ Email ______

Siblings and Their Ages ______

List any other family members receiving care here: ______

Health History

Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

Did you have ultrasound during this pregnancy?: ______ If so, frequency?: ______

Place of Birth: Home ○ Hospital ○ Birthing Center ○ Other: ______ Provider (OB-Gyn/Midwife): ______

Type of Birth: Vaginal ○ C-Section ○ Was anesthesia used? ______ Type: ______

Was labor induced?: ______ Why? ______ What position did you deliver in? ______

Birth Trauma: Doctor assisted ○ Twisting ○ Pulling ○ Vacuum Extraction ○ Forceps ○ Other: ______

Newborn Trauma (procedures and tests): ______

Did you breast-feed your child?: Yes ○ No ○ If yes, How long?: ______

Below, please fill in any other health information you feel we might need for your care: ______

Subluxation Assessment

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 result 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 you child's inborn health and well-being.

According to the national Safety Council approximately 50% of infants have fallen on their heads during their first years of life. Another study reveals that 250,000 children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? ______

______

Any fractures or dislocations?: ______ What sports does your child play?: ______

Besides in the classroom, does your child sit for a prolonged period?: ______ Is it in front of a computer or TV? ______

Approximately how many hours each day is your child looking down at a tablet/phone/other device: ______

How would you rate your child's diet?: ______

Do they consume artificial sweeteners? ______ Fluoridated water? ______

Please check any of the following conditions your child has experienced: colic ○ irregular sleeping patterns ○ night terrors ○ tantrums ○ seizures ○ ear infections ○ allergies ○ asthma ○ headaches ○ poor digestion ○ repeated infections ○ repeated colds ○ bed wetting ○ learning disorders ○ emotional disorders ○ ADD ○ ADHD ○ other: ______

How often has your child been treated with drugs?: ______ Were you informed of adverse reactions? ______

If it was an antibiotic were they cultured for it and how?: ______

Please list any medications your child is currently taking: ______

Please list any surgeries and when: ______

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	○	○
Migraines	○	○
Neck Pain	○	○
Shoulder Pain	○	○
Arm/Hand Pain	○	○
Mid Back Pain	○	○
Low Back Pain	○	○
Hip Pain	○	○
Leg/Foot Pain	○	○
Disc Problems	○	○
Arthritis	○	○
Other Joint Pain	○	○
Numbness	○	○
Joint Swelling	○	○
Dizziness	○	○
Nausea	○	○
Weakness	○	○
Fatigue	○	○
Nervousness	○	○
Insomnia	○	○
Heart Problems	○	○
Frequent Colds	○	○
Nose Bleeds	○	○
Ringing in Ears	○	○
Earaches	○	○
Hearing Loss	○	○
Cough	○	○
Chest Pains	○	○
Female Problems	○	○
Allergies	○	○
Asthma	○	○
Cancer	○	○
Osteoporosis	○	○
Diabetes	○	○
Hypoglycemia	○	○
Digestive Problems	○	○
Urinary Problems	○	○
Skin Conditions	○	○
Other___________	○	○

Circle the areas where you have any problems.

Thank you for being complete and thorough.
Your Signature Below Please

Date:

For Office Use Only Below
Dr Notes

ProWellness Chiropractic

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: ______________________________
Printed Name-Patient or Responsible Party

____
Patient Signature or Responsible Party Date

____
Relationship to patient (if other than patient)

Witness: ______________________________
Printed Name-Practice Representative

____
Signature Date

Authorization For Use of Health Care Information

Your personal health information, including your clinical records and billing information, may be disclosed to another health care provider, insurance carrier for further diagnosis, assessment, or for payment of services.

(More information on how, when and why we will use your health care information can be found on the HIPAA patient consent form in this packet.)

Social Media Photo/Video Release:

We use social media to spread the word about chiropractic care and market to potential new patients. We ask your permission to use, re-use, publish and republish photographic portraits or pictures, videos or any other social media content with you in it. You are authorizing that all media or reproduction hereof in color or otherwise may be used to promote or advertise ProWellness or any of its employees.

Because of our Federal Tax ID and business registration your Explanation of Benefits may show visits from our office as services being performed by Freedom Chiropractic doing business as Prowellness Chiropractic.

We

Patient Authorization for Referral Thank You Cards and Testimonials:

If you respond favorably to chiropractic care, you may be asked to fill out a "patient testimonial," you may decline if you wish. This will help others to read the success of chiropractic. If you choose not to authorize this information your decision will not have an adverse effect on your care from our office or on your relationship with our staff.

Open Adjusting Environment:

Our office is an open adjusting environment. Your examinations, X-rays and report of findings are performed in the privacy of a closed room. Conversations between you, your doctor and our staff during normal treatments may be overheard by others in the building. Our goal is to maintain as much privacy as possible. If you are uncomfortable discussing your case, you may request a private consultation for your next visit.

Cancellation Policy for Chiropractic:

- Please arrive on time to your scheduled appointment in order to ensure a complete treatment/session.
- If you arrive late to your appointment we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.
- You may cancel/reschedule your appointment without charge anytime before the time of your appointment.
- If you do not call to cancel/ reschedule your appointment, you will be considered a no-show, and will be charged our cash rate of $49.00 for that scheduled service, no matter your original rate.
- **No-show charges are not covered by your insurance.**
- **All charges must be paid in full by your next appointment.**

Cancellation Policy for Massage and Acupuncture:

- You may cancel your appointment without charge anytime before the close of business on the business day preceding your appointment.
- Same day cancellations will be charged 50% of the scheduled service price.
- If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be considered a no-show and will be charged the full price for the scheduled service.
- If you are sick or not feeling well please notify us as soon as possible so we can reschedule your massage. Chiropractic adjustments can be beneficial to your immune system but we prefer to not risk the health of our massage therapist. If you arrive to your scheduled massage and are unwell you may be asked to reschedule for a later date. We thank you for your understanding in this matter.

Your signature indicates you have read, understand and authorize the above activities.

______________________________	____________________________________	______/______/______
Printed Name	Signature	Date

If you are under the age of 18 you must be represented by a parent or guardian.

______________________________	____________________________________	______/______/______
Printed name of Parent or guardian	Signature	Date

*This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable time for the change in our system to be complete.