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 ofthen 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:

Are there any injured areas or conditions, such as bruises, cuts, sores, abnormal blood pressure, blood clots or cancer that may be aggravated by treatment today? [No] [Yes] – What?

Does your child have any allergies to fragrances, flowers, oils, or topical creams? [No] [Yes]
What?_____

In undertaking treatment at ProWellness, I (print name)_____
Agree that: The purpose of the adjustment/massage is to provide stress relief, pain control and relax. The therapist will not treat, prescribe or diagnose an illness, disease or any other physical or mental disorder. Nothing said in the course of a massage session should be misconstrued to be such. I understand that a massage involves having my body touched. I hereby authorize the therapist to perform massage. I understand that any relief of physical or emotional symptoms is the product of processes, which reside within me. The power to heal comes from within. I understand that I am responsible for my emotions, feelings, body and belongings and the therapist is responsible only for giving a massage. Control of the session is always mine and I can stop it at any time. In the spirit of this understanding, I agree to hold ProWellness and its employees blameless from any problem which may arise as a result of my massage.

**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.

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

Witness at ProWellness Chiropractic Signature Date

**INFORMATION CONSENT TO RECEIVE CHIROPRACTIC CARE**: I, the undersigned, give the doctor permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis, and treatment. Chiropractic care seldom causes any complications, but in rare cases, due to underlying physical defects, deformities or pathologies may render a patient susceptible to injury. The doctor will not provide care if they are aware of any contraindication that may be present. It is the responsibility of the patient to make it known to the doctor or health care provider if they are aware of any underlying deformities or defects that may not otherwise come to the attention of the doctor.

**Insurance and your corrective care plan:**

1. Cost of your care plan may change based on the actual insurance coverage for services rendered. Your insurance company may only cover charges based on medical necessity.
2. This agreement will become null and void if your insurance company does not find your care medically necessary. A new care plan with the appropriate financial revisions will be presented to you in this situation.
3. You are responsible for reporting any insurance coverage changes to this office. Care plan cost may be revised upon a change of insurance coverage.

**Our Recommended Care:** Based on cases similar to yours and current scientific literature, we have estimated the following time period for your care plan. This is only an estimate and is dependent upon factors such as: physiological properties, arthritis, age, gender, patient compliance, etc. Because of the variables involved, there can be no guarantee to the results you will experience.

**Authorization For Use of Health Care Information**

I authorize my healthcare provider, and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

**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.**

**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 and Massage:**

- 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 24 hours 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 for that scheduled service, no matter your original rate. ($38/adjustment, $75/hr. massage, $45/30 min. massage)
- **No-show charges are not covered by your insurance.**
- **All charges must be paid in full by your next appointment.**

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.