Wilson Family Chiropractic

Pediatric Patient Information

NAME: _____ BIRTH DATE: _____

PARENT/GUARDIAN(S) NAME: _____

ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

PHONE: (H) _____ (C) _____

EMAIL: _____

CHILD'S BIRTH WAS: __ NATURAL VAGINAL BIRTH __ SCHEDULED C-SECTION

__ EMERGENCY C-SECTION

AT HOW MANY WEEKS WAS YOUR CHILD BORN? _____

CHILD'S BIRTH WAS: __ AT HOME __ AT HOSPITAL __ OTHER

PARENT'S NAME(S): _____

PLEASE INFORM US OF ANY APPLICABLE INTERVENTIONS OR COMPLICATIONS:

_____

_____

IS/WAS YOUR CHILD BREASTFED? _____

DIFFICULTY WITH BREASTFEEDING? _____

DID THEY EVER USE FORMULA? _____ IF YES, WHAT AGE? _____

IF YES, WHAT TYPE? _____

HAS YOUR CHILD SUFFERED FROM COLIC, REFLUX, OR CONSTIPATION?

_____

Let's Find Out Why You're Here!

REASON FOR SEEKING CHIROPRACTIC CARE: _____

_____

ANY OTHER SPECIFIC CONCERNS: _____

LIST OF ALL CURRENT MEDICATIONS/CONDITIONS BEING TREATED: _____

_____

LIST ANY PAST SURGERIES/DATES: _____

_____

LIST ANY PAST INJURIES/DATES: _____

_____

HAS YOUR CHILD EVER VISITED A CHIROPRACTOR? __
ARE YOU FAMILIAR WITH THE CHIROPRACTIC TERM, SUBLUXATION? __

Growth & Development History

At what age did your child:

__ Respond to sound
__ Follow an object
__ Hold their head up
__ Vocalize
__ Teethe
__ Sit up alone
__ Crawl
__ Walk
__ Begin cow's milk
__ Begin solid food

Did/does your child frequently arch their neck or bang their head?

_____

Please list any food intolerence or allergies, and when they began:

_____

TOP THREE HEALTH GOALS FOR YOUR CHILD: _____

_____

Pregnancy & Fertility History

__ Any fertility issues? If yes, please explain:

_____

__ Was mother ill? If yes, please explain:

_____

__ Did mother smoke?
__ Did mother drink?
__ Did mother exercise?
__ Any ultrasounds?

Please explain any notable episodes of mental or physical stress during your pregnancy: _____

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

_____

Did/does your child frequently arch their neck or bang their head?

_____

Please list any food intolerence or allergies, and when they began:

_____

Have you chosen to vaccinate your child? If yes, please list any vaccination reactions:

Has your child received any antibiotics? If yes, list reason:

Night terrors or difficulty sleeping? YES NO
If yes, please explain:

Behavioral, social or emotional issues?
If yes, please explain:

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

How would you describe your child's diet? __ Mostly whole, organic foods
__ Pretty average __ High amount of processed foods

Let's Make Sure We're On the Same Page

When an individual or family seeks and is accepted into a program of function-based chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward the objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of medicine. Medically-based care specializes in the diagnosis and treatment of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nervous systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

While the natural result of optimal function is increased health, wellness, and an overall improved quality of life, we will not treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a specific medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease-oriented professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Joshua to continue with my child's and/or initial consultation and assessment. I also agree to return at a later date to allow Dr. Wilson to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed:_____ Date: _____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well-being, as well as your goals.
We look forward to helping you maximize your experience and expression of health & life!

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually to the vertabra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;

2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of electricity, traction, motion, nutritional advice, heat, or cold;

3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation or new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;

4. That the chiropractor has made no guarantee or a positive outcome for treatment.

5. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the procedures performed by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I consent to the performance of other procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case

Patient Signature: _____

Parent/guardian signature: _____

Patient Name: _____ Date of Birth: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need. If you are pregnant, or expected to be, please mark through this portion.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you further acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescind-able agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned or supplier for service described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office-related matters in the following manner: phone-work-home or mobile, e-mail, and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures

ACKNOWLEDGEMENT: By signing below you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Name of Patient: _____

Signature of Parent or Guardian: _____