

Davis County Spinal Care, PC
Child Information

Congratulations on your decision to see us to improve your child's life!

Child's name _____
Child's Birth Date _____ Social Security # _____
Parent(s) name _____ Date _____

Address _____

The following is in regards to the parent:
Home Phone _____ Work Phone _____ Cell _____
(Please circle the phone number that is best to reach you at during our office hours.)

How did you discover our office? _____
Reason for consulting our office today: _____
What are your expectations for your child's care in this office? _____

Please list any concerns for your child in order of importance:
1. _____ 2. _____ 3. _____

Have you seen any other professional for these concerns? Y N
If yes, describe the treatment and any results:

Please check each of the following that has ever applied to your child

- | | | |
|--|---|---|
| <input type="checkbox"/> Sick a lot | <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> School difficulties |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Poor balance or coordination | <input type="checkbox"/> Stress or Anxiety |
| <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Social fears/ problems |
| <input type="checkbox"/> Frequently unhappy | <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Scoliosis/ Spinal problems |
| <input type="checkbox"/> X-rays or MRI | <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Car accident |
| <input type="checkbox"/> Spinal or Head injury | <input type="checkbox"/> Falls | <input type="checkbox"/> Neurological conditions |
| <input type="checkbox"/> Birth Trauma (forceps, vacuum, c-section) | | <input type="checkbox"/> Slow development |
| <input type="checkbox"/> Headaches | | |

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your child.

Has your child ever been to a Chiropractor before? Y N When _____
Why did you go? _____
What were the results? _____
Why did you stop going? _____
Does your child have any conditions that may alter the way in which their care is delivered?

Please describe your child's:
Sleep _____
Diet _____
Exercise _____
Does your child take any vitamins, supplements, or medications? (Please explain)

Does your child participate in any sports, lessons, talents, or hobbies? (Please explain)

What is it that you want most for your child?

Is there anything else that we need to know about your child that was not addressed on this form?

Payment Policy

Payment is due at the time of, or previous to, services being rendered. Before any Professional services are rendered all fees will be explained. If you have insurance you may be able to be reimbursed for part of your expenses at our office.

We ask that you kindly give 24 hours notice to change an appointment. Office policy is that missed appointments that are not cancelled or rescheduled with 24 hours notice are subject to a \$20 fee for each 10 minute time period scheduled.

Our office is constantly improving; therefore all policies are subject to change (for the better ☺).

Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather we care for the spine for the sole purpose of removing interference with and tension from the Nervous System. We also employ extremity work to improve muscle and joint stability and function. Every person is better with improved neural, and musculo-skeletal function and this alone justifies our care. Research studies report improved health and wellness that is consistent with the care given. However, just what specific benefits your child will receive, no one can predict.

By my signature I give my consent to Davis County Spinal Care, PC to use my client information and for a Doctor of Chiropractic to examine my child's spine and extremities. If I choose for my child to receive Chiropractic care, my payment for such services, and my bringing my child to each visit, in addition to my signature here; will serve as acknowledgment of my permission for a doctor of chiropractic to deliver such care to my child.

Privacy Notice

Your Child's health information is private and protected by law. This health information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations in this office. You have a right to review the office file. You may restrict all or part of the health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

Each practitioner at Advanced Health Clinic, LLC is a private contractor and works separately. At times a client may benefit from the services of more than one practitioner. In the event a referral is made, I allow other practitioners to review the file and/or discuss my child's health needs with me or my chiropractor.

I have had a chance to ask questions about the privacy policy and I give my permission to Davis County Spinal Care, PC to disclose my protected health information in accordance with such policies.

Signature

Date

Witness Signature

Date