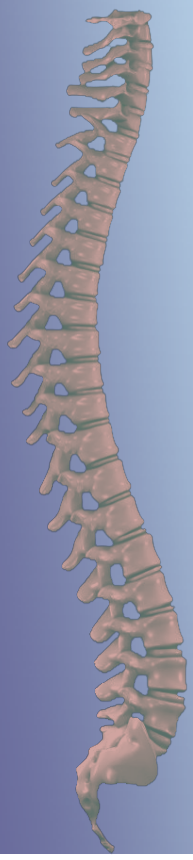
CADENCE CHIROPRACTIC

Welcome to our office!

It is well known that families who maintain strong, healthy, well-aligned spines have greatly improved health. People whose spines are not healthy and kept in proper alignment are much more likely to develop serious health challenges later in life.



CHILD CHIROPRACTIC INTAKE FORM

MY PURPOSE FOR TODAY'S APPOINTMENT IS:

(*check all that apply to you)*

□ We are here for an evaluation. My child is a healthy person and I'm interested in maximizing his/her health and preventing future problems.

□ We are here for an evaluation because my child is having health challenges and we are looking for a natural health solution.

□ We are here for an evaluation. I am curious to know if my child's spine is healthy and to see if he/she has any problems that I don't know about.

□ We are here for an evaluation for my child because I'm curious to learn more about Chiropractic Care.

□ We are here for an evaluation for my child only.

□ Other

IF THE DOCTOR FEELS THAT SHE CAN HELP YOU:

(Please check the one that best applies to you)

□ We are willing to follow the doctor's recommendations because we strongly value our health.

□ We are willing to receive care if payment plans are available.

□ We are willing to receive care but only if our insurance pays for all of it.

□ We are not interested in receiving any future care.

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's natural wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's natural ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's natural wisdom. Our only method of achieving this is through specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction.
Signature_____ Date _____

Consent to Treatment of Minor Child

I hereby authorize Cadence Chiropractic to administer treatment as they so deem necessary to my daughter / son / other, (name) _____.

Signature: _____ Date: _____

Witness: _____ Date: _____

Whom may we thank for referring you to this office? _____

PEDIATRIC PATIENT HEALTH HISTORY

Today's Date: _____ File #: _____

PATIENT DEMOGRAPHICS

Childs Name: _____ Birth Date: _____-_____-_____ Age: ____ ☐ Male ☐ Female

Mother's Name: _____ Father's Name _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile :_____

Do you have Insurance: ☐ Yes ☐ No **Please provide us with your insurance card so we may photocopy.

PATIENT HISTORY

Type of Birth (check all that apply): Normal/Vaginal____ Forceps ___ Breech ___ Cesarean ___ Home ___ Hospital ___

Problem during pregnancy? _____

_____

Problem with labor/delivery? _____

_____

APGAR Scores: _____ _____ Present at Birth: Jaundice (yellow) _____ Cyanosis (blue) _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast _____ Bottle _____ Formula _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Immunization History _____

Any childhood diseases? _____

Previous Surgery _____

Medications _____

Accidents/Falls _____

Family History _____

Has your child ever been treated on an emergency basis: Y of N If Yes, why? _____

Purpose of last visit to MD _____ Date: _____

Purpose of this appointment _____

DEVELOPMENTAL HISTORY

At what age did the child… ?

Smile:	Stand:	Walk alone:	Crawl:	Hold object with hands:
Hold head up:	Sit alone:	Follow object with his/her eyes:	Talk:	

Has the child ever suffered from: (circle all that apply)

Dizziness	Rheumatic fever	Cold/flu	Paralysis
Diabetes	Broken bones	Allergies	Neck problems
Anemia	Ruptures/hernias	Bed wetting	Joint problems
Poor appetite	Blood disorders	Diarrhea	Arm problems
Bed wetting	Heart troubles	Constipation	Leg problems
Behavioral problems	Diabetes/hypoglycemia	Asthma	Walking problems
Backaches	"Growing pains"	Hyperactivity	
Headaches	Stomach aches	Fainting	
Digestive disorders	Chronic earaches	Seizures	

* Any other: _____

I hereby authorize payment to be made directly to Cadence Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cadence Chiropractic for any and all services my child receives at this office.

_____ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____

Doctor's Signature **Date Form Reviewed**

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records; we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-ray in our files.

The fee for copying your X-Rays and Video Fluoroscopy study on a disc is $10.00. This fee must be paid in advance.

Digital X-Rays on CD will be available within 72 hours of prepayment and on regular practice hour days.

PLEASE NOTE: X-Rays are utilized in this office to help locate and analyze vertebral subluxations. These X-Rays are not used to investigate for medical pathology. The doctors of Cadence Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you may seek proper medical advise.

By signing below you are agreeing to the above terms and conditions.

_____ _____

Patient Name (Print) Patient Age

_____ _____

Parent/Guardian's Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Cadence Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

_____ _____

Parent/Guardian's Signature Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that a more comprehensive version of this "Notice Of Privacy Practice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

_____ _____

Parent/Guardian's Signature Date

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Release of Information*:*

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This "**Release"** will remain in effect until terminated by me in writing. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

Messages*:*

Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

_____ _____

Parent/Guardian's Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctors by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							
Do you use orthotics?							