**Family Chiropractic Center, Inc.**
**Optimal Health Center, LLC**
**4201 Bee Cave Road**
**Suite C212**
**Austin, Texas 78746**
**(512) 347-8033**
**www.famchiro.com**

We want to welcome you to the Family Chiropractic Center and Optimal Health Center.

Our goal is to provide for your health needs through the use of modern chiropractic and natural health techniques. We look forward to serving you.

Our office is located in the Schoolyard, an office park just west of Eanes Elementary School on Bee Cave Road. Suite C212 is in Building C, at the back of the complex.

Please arrive wearing comfortable, loose-fitting clothing and allow up to 90 minutes for your initial appointment.

Attached you will find a “Patient History”. Please print and complete it. This will allow us to focus your examination on the matters of maximum importance to you. Bring your history along with a photo ID and your insurance card to your first visit.

An acknowledgment of our “Privacy Policies & Consents” is included at the end of the history. A complete version of these policies is either included as a separate file or is available on our website. Please review the complete document prior to signing the acknowledgement.

If you have any questions prior to your appointment, please call or email info@famchiro.com.

Supporting your well being,

*Your Doctors and Staff*

# PEDIATRIC CONFIDENTIAL INFORMATION (CHILDREN UNDER 18 YEARS)

We appreciate the opportunity to support your child in meeting desired health outcomes. Please assist us by completing the following information.

**Child:** Last Name First Name Nick Name

DOB Age Cell Phone Email

Height: ft in Current Weight: Weight One Year Ago:

Primary Care Physician:

Other Current Health Providers:

How Would You Rate Child's Current Overall Health? /10 What Would You Like Health To Be? /10

***Health Goals:*** People consult our office with one or more health objectives. *Please indicate desired outcomes:*

☐ Wellness + Prevention ☐ Get my child's health back and maintain optimal health

☐ Relief of current symptoms ☐ Minimal activity limitations ☐ No activity limitations

☐ Correction of underlying health problems ☐ Learn exercises or other things to help at home

***Top 3 Goals:*** **1)**

**2)**

**3)**

**Parent's Info:** Mother's Name Father's Name

Street Address, City, State & Zip

Cell Phone Home Phone Work Phone

Email Occupation

Names & Ages of Other Children

Emergency Contact Relationship Phone

Preferred Communication: Text / Email / Phone Health Insurance Co.:

How Did You First Hear About Our Office? ☐ Friend ☐ Website ☐ Google ☐ Yelp ☐ Other Social Media

Who May We Thank For Referring You To Our Office?

Signature: _____ Date: _____

# CHILD'S HEALTH HISTORY

*Life is a journey. Health status is a result of many factors and experiences had along the way. To best assess how we may best help your child, we are interested in events and stressors that may have played a part through their formative years as well as current factors.*

***Pre-Pregnancy***

| Did child's parents… | Yes | No | Unsure |
|---|---|---|---|
| Plan and welcome the pregnancy? | ☐ | ☐ | ☐ |
| Prepare their bodies for conception and pregnancy? | ☐ | ☐ | ☐ |

***Pregnancy***

| Did child's mother… | Yes | No | Unsure |
|---|---|---|---|
| Have chiropractic care during pregnancy? | ☐ | ☐ | ☐ |
| Exercise through pregnancy? | ☐ | ☐ | ☐ |
| Have a nutritious diet during pregnancy? | ☐ | ☐ | ☐ |
| Have any significant health challenges / illness during pregnancy? | ☐ | ☐ | ☐ |
| Have any significant injury during pregnancy? | ☐ | ☐ | ☐ |
| Have any significant stress during pregnancy? | ☐ | ☐ | ☐ |
| Smoke, drink alcohol or take drugs during pregnancy? | ☐ | ☐ | ☐ |
| Were ultrasounds performed on mother? | ☐ | ☐ | ☐ |

Please explain any other concerns or other notable considerations about child's conception or pregnancy

_____

_____

***Birth Process***

| Was child's birth… | Yes | No | Unsure |
|---|---|---|---|
| Home birth or at birthing center? | ☐ | ☐ | ☐ |
| Hospital birth? | ☐ | ☐ | ☐ |
| Early or late according to due date? | ☐ | ☐ | ☐ |
| A long or difficult delivery? | ☐ | ☐ | ☐ |
| Scheduled caesarean delivery? | ☐ | ☐ | ☐ |
| Emergency caesarean delivery? | ☐ | ☐ | ☐ |

Please check any other applicable interventions or complications:

☐ Breech ☐ Cord wrapped ☐ Induction ☐ Pain Meds
☐ Epidural ☐ Manual Assistance ☐ Episiotomy ☐ Vacuum Extraction
☐ Forceps ☐ Other:

***Chemical Exposure***

| | Yes | No | Unsure |
|---|---|---|---|
| Was child breast fed? If so, how long? _____ months | ☐ | ☐ | ☐ |
| Any difficulty breast feeding? | ☐ | ☐ | ☐ |
| Was there a side that was difficult for child? _____ | ☐ | ☐ | ☐ |
| Was child bottle fed? If so, how long? _____ months | ☐ | ☐ | ☐ |
| Was formula used? If so, how long? _____ months | ☐ | ☐ | ☐ |
| Was child vaccinated? | ☐ | ☐ | ☐ |

☐ Yes, on schedule ☐ Yes, delayed or selective schedule

List any vaccination reactions:

_____

| | | |
|---|---|---|
| Is child mainly fed nutritious home-cooked meals from fresh ingredients? | ☐ | ☐ |
| Is child mainly fed processed convenience foods and fast foods? | ☐ | ☐ |
| Does child mainly drink filtered or purified water vs tap water? | ☐ | ☐ |
| Does child often drink sodas or sugary tea, etc.? | ☐ | ☐ |
| Does child crave sweets and regularly eat candy or sugary foods? | ☐ | ☐ |
| Does child use artificial sweeteners? | ☐ | ☐ |
| Has child received any antibiotics? | ☐ | ☐ |

If so, how many times, and reason:

_____

| | | |
|---|---|---|
| Has child received any other medications? | ☐ | ☐ |

If so, what, how many times, and reason:

_____

***Current Medications:*** ☐ None _____

_____

***Food Allergies:*** ☐ Gluten ☐ Dairy ☐ Other: _____

| Did / Does Child Suffer from Any of the Following as An Infant? | Yes | No | Unsure |
|---|---|---|---|
| Colic | ☐ | ☐ | ☐ |
| Reflux | ☐ | ☐ | ☐ |
| Skin Issues | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |

***Family Medical:*** Please note any significant family medical history. _____

_____

***Physical Development & Stresses***

| At What Age Did Child | Age | At What Age Did Child | Age |
|---|---|---|---|
| Respond to Sound | | Crawl | |
| Follow an Object | | Walk | |
| Vocalize | | Begin Cow's Milk | |
| Begin Teething | | Begin Solid Foods | |
| Sit Alone | | Begin Socializing with Other Children | |

| Does Child Exhibit These Behaviors or Has Child Experienced… | Yes | No | Unsure |
|---|---|---|---|
| Arching neck or back? | ☐ | ☐ | ☐ |
| Stiffening neck, back or body? | ☐ | ☐ | ☐ |
| Physical abuse by siblings or others? | ☐ | ☐ | ☐ |
| Being violently pulled by arm as a child? | ☐ | ☐ | ☐ |
| Self-abuse: head-banging, cutting, etc.? | ☐ | ☐ | ☐ |
| Get hit or fall on head? | ☐ | ☐ | ☐ |
| Have a major fall, as in down stairs? | ☐ | ☐ | ☐ |
| Auto accident or other trauma? | ☐ | ☐ | ☐ |
| Sports injuries? | ☐ | ☐ | ☐ |

Explain Further: _____

_____

| ***Mental / Emotional Stress*** | Yes | No | Unsure |
|---|---|---|---|
| Was there communication breakdown in childhood home? | ☐ | ☐ | ☐ |
| Was there the loss of a parent or close relative | ☐ | ☐ | ☐ |
| Was there ongoing stress in family? | ☐ | ☐ | ☐ |

Please provide details of above or other stresses experienced.

_____

Has child experienced a loss in the last 5 years? (e.g. relationship, family) Y N (If yes, please describe)

_____

Any significant current stresses? ☐ Home ☐ School ☐ Family ☐ Other _____

_____

***Child's Lifestyle:***

Current Sports: _____

Injuries: _____

Surgery: _____

| ***Child's Daily Habits:*** | Yes | No | Unsure |
|---|---|---|---|
| Stays well hydrated? | ☐ | ☐ | ☐ |
| Mainly eats nutritious home-cooked meals from fresh ingredients? | ☐ | ☐ | ☐ |
| Exercises regularly? | ☐ | ☐ | ☐ |
| Are teeth healthy? | ☐ | ☐ | ☐ |
| Is 'screen time' a major part of child's day? | ☐ | ☐ | ☐ |
| Frequently sit for hours at a time? How many hours sitting a day? _____ | ☐ | ☐ | ☐ |

***Reason For Seeking Care Now:*** ☐ Wellness Care ☐ Treatment of health concern (Please Describe)

_____

_____

***Describe When Child's Issues Began and How They Have Progressed:***

_____

_____

***What Makes Things Better:*** _____

_____

***What Makes Things Worse:*** _____

_____

| Additional Health Concern | Severity 1 = Mild 10 = Worst | % of Time It is Present | When Did It Begin? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**Any Other Concerns We Should Be Aware Of:** _____

_____

**Recent Medical Care or Other Treatment:** _____

_____

_____

**Previous Chiropractic Care?** Y N Dr Name: _____ Last Visit: _____

What type of care did they provide?

☐ 'Limited Scope' Chiropractor (Focuses mainly on neck and back pain)

☐ Nutrition Support ☐ Physical Therapy & Rehab

☐ 'Optimal Health' Chiropractor (Focuses on optimal health as well as the underlying causes of pain and health concerns)

***Additional Lifestyle Information:***

**Sleep Habits** (please fill in or circle the appropriate answer)

1. How well does your child sleep?
   Well  Trouble falling asleep  Trouble staying asleep  Insomnia
2. Does your child wake up tired?  Yes  No
3. How many hours does your child sleep on an average night? _____
4. Does your child take naps?  Yes  No
5. Does your child have nightmares?  No  Sometimes  Often

**For Cycling Females Only** (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): _____
   Approximate Date: _____
2. Is your child currently using any method of birth control?  Yes  No
   What kind?  Oral Pill  Injected  Patch  Ring
3. How long has your child been using birth control? _____
4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):

_____

_____

_____

_____

5. First day of last period: _____
6. Length of typical period: _____
7. Is menstrual cycle regular?  Yes  No  Not Always
   Details: _____
8. How many pads and / or tampons (please circle) are used on heavy days?

_____

9. Any knowledge of passing clots?  Yes  No
   How often? _____
10. Any spotting between periods?  Yes  No
    At what point in cycle? _____
11. Does your child experience cramping?  None  Mild  Moderate  Severe
    At what point in the cycle? _____

## *Systems Review*

***Please Mark All That Apply and Provide Details***

| SIGNS & SYMPTOMS | MILD | MODERATE | SEVERE | MORE INFORMATION |
|---|---|---|---|---|
| Low Mood | | | | |
| Lowered Self-Esteem | | | | |
| Discouragement | | | | |
| Sadness / Crying | | | | |
| Reserved / Withdrawn | | | | |
| Decreased Interest in Activities | | | | |
| Decreased Initiative / Motivation | | | | |
| Behavior Problems | | | | |
| Aggression | | | | |
| Anger | | | | |
| Anxiety | | | | |
| Fear | | | | |
| Difficulty Concentrating | | | | |
| Foggy Thinking | | | | |
| Memory Problems | | | | |
| Constant Hunger | | | | |
| Never Hungry / Anorexia | | | | |
| Weight Loss | | | | |
| Weight gain | | | | |
| Decrease in Strength / Stamina | | | | |
| Decrease in Athletic Performance | | | | |
| Fatigue | | | | |
| Anemia | | | | |
| Headaches / Migraines | | | | |
| Body / Joint / Backaches | | | | |
| Digestive Problems | | | | |
| Irritable Bowel | | | | |
| Constipation | | | | |
| Loose Stool / Diarrhea | | | | |
| Bloating | | | | |
| Frequent Urination | | | | |
| Bedwetting | | | | |
| Allergies | | | | |
| Asthma | | | | |
| Throat Clearing | | | | |
| Excessive Mucous / Runny Nose | | | | |
| Dry Skin | | | | |
| Acne | | | | |
| Cold Sores | | | | |
| Infections / Lowered Immunity | | | | |

# Family Chiropractic Center, Inc. / Optimal Health Center, LLC
# Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Evaluation, Treatment and Financial Policies

**Notice of Privacy Practices** I have read and understand the Family Chiropractic Center, Inc. / Optimal Health Center, LLC Notice of Privacy Practices; ***"Your Information. Your Rights. Our Responsibilities"*** as well as "Informed Consents" which describe how my Protected Health Information (PHI) may be used or disclosed. I understand that I may request a copy of the Notice at the Front Desk or view it at our website, www.famchiro.com

**Informed Consent and Authorization for Chiropractic Evaluation and Treatment:** I understand that although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are possible risks and complications associated with these procedures. I have read and understood the description of common risks associated with these procedures. I hereby authorize the doctors of FCC / OHC to perform the history, diagnostic and examination procedures they deem necessary related to conditions presented in this office.

I understand that the doctors have the right to refuse or accept me as a patient at any time before treatment begins. Should they accept me for treatment, I give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that chiropractic procedures may consist of adjustments involving movement of the joints and soft tissues. Adjunctive physical therapy, exercises and nutritional therapy may also be used in my treatment. I understand that there may be additional risks associated with any of these forms of treatment. Should I have any adverse reactions to treatment, I will notify my doctor as soon as possible. I intend this consent to apply to all present and future chiropractic care received in this office.

**Non-Covered Services Policy:** I understand that insurance companies will not cover a portion of the services or supplies I receive at this office for reimbursement. I will be informed in advance of these items. They will not be billed to my insurance company and will be my sole financial responsibility. The following is a partial list of these services and their standard fees at the time of this notice:

| | |
|---|---|
| Insight Neuro-diagnostic Scan Suite | $ 55 |
| Neuro-Muscular Reflex Examination | $ 45 |
| Muscle Priority Assessment | $ 25 |
| Optimal Health / Wellness Visit | $ 80 |
| Nutritional Supplements / Supplies | Varies |

**Informed Consent of Appointment Scheduling Policies** If I discover that I am not able to make a scheduled appointment, I will notify this office at the earliest possible opportunity. **I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to cancelling or rescheduling an appointment, I will be responsible for paying for that appointment in full.**

**Authorization for Direct Payment to Family Chiropractic Center, Inc.** Should I have an outstanding balance on my account with Family Chiropractic Center, Inc., I authorize direct payment of my medical benefits to Family Chiropractic Center, Inc. for the health care services rendered to me. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that I am personally responsible for these services should they not be covered by insurance.

**Signature**
I have reviewed and agree with this consent form. I also give my permission to this office to use and disclose my health information in accordance with the described Protected Health Information Policies.

_____ _____ _____
**Name of Patient (print)** **Signature of Patient (Or Patient Parent/Representative)** **Date**

_____ _____
**Office Representative** **Date**

**Direct Questions to Privacy Official:**
Dr. Mark Sanders
info@famchiro.com
(512) 347-8033

Revised March 7, 2024