justice family chiropractic

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PEDIATRIC PATIENT INFORMATION

Name:_____(Age)_____Gender: M F

Home Address:_____Cell Phone: ( ) _____

City, State, Zip:_____Home Phone: ( ) _____

Email Address:_____Work Phone: ( ) _____

Birth Date:_____/_____/_____Social Security #:_____-_____- _____

Parent's Name: _____

Parent's Occupation:_____Employer: _____

Other Parent's Name:_____Work Phone: ( )_____Cell Phone: ( ) _____

Other Parent's Occupation:_____Employer: _____

How were you referred to this office? _____

INSURANCE INFORMATION

Primary Ins. Company:_____Ins. Phone #: _____

ID#:_____Group #: _____

Name of Policy Holder:_____Policy Holder DOB: _____

Policy Holders Employer: _____

Secondary Ins. Company:_____Ins. Phone #: _____

ID#:_____Group #: _____

Name of Policy Holder:_____Policy Holder DOB: _____

Policy Holders Employer: _____

PURPOSE(S) OF THIS VISIT

Reason for this visit – Main Complaint:

Is this purpose related to an auto accident? □ Yes □ No If so, when: _____

When did this condition begin?_____/_____/_____Did it begin: Gradual Sudden Progressive over time

What activities aggravate your child's symptoms? _____

Is there anything that has relieved your child's symptoms? □ Yes □ No Describe:_____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Is this condition getting worse? □ Yes □ No Explain:_____

How often does your child experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with Activity

Rate the pain (if present) on Scale between 0-10, 10 being Severe Pain: Right Now_____ At its Worst_____At its Best _____

Does complaint(s) interfere with: __School __Sleep __Hobbies__Daily Routine Explain:_____

Has your child experienced this condition before? □ Yes □ No If so, please explain:_____

Who has your child seen for this?_____What did they do? _____

How did your child respond? _____

CHILD'S HEALTH HISTORY

Child's birth was: At Home / In a Hospital / At a Birth Center; Which Facility:_____

My obstetrician / Midwife / Family Physician was: _____

Child's birth was: Natural Vaginal (no medications/interventions) / Vaginal with Intervention (medications, induction, forceps, vacuum)

C-section birth: Scheduled / Emergency – List reasons why:_____

Child's birth weight and height:_____Current weight and height: _____

Child's Hospitalization and Surgical History: _____

_____

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime, including the year:

_____

Is/was your child breastfed? Yes/No If Yes, how long? _____

Was formula ever introduced? Yes/No If Yes, at what age?_____

Introduction of cow's milk at age?_____ Introduction of solid foods at age? _____

Briefly explain any difficulties during the pregnancy of this child:_____

List any drugs/medications (including over the counter) taken during pregnancy: _____

_____

Any exposure to ultrasound? Yes/No If so, how many and what was the medical reason? _____

Has child received any vaccinations? Yes / No If yes which ones and list any reactions _____

_____

Has child received any antibiotics? Yes / No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? Yes / No If yes, please explain _____

_____

Any behavior problems? Yes / No If yes, please explain _____

_____

Current Medications? Past Medications Yes / No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? Yes / No If yes, please explain _____

_____

EXPERIENCE WITH CHIROPRACTIC

Has your child seen a chiropractor before? □ Yes □ No Who?_____When? _____

Reason for visits: _____

How did he/she respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

HEALTH LIFESTYLE

Do your child exercise? Yes No If yes, how so? _____

Does your child take any supplements (i.e. vitamins, minerals?)_____

_____

HEALTH CONDITIONS

☐ Anxiety/Depression	☐ Fatigue/Sleep Issues	☐ Digestive Troubles	☐ Dizziness	☐ Nausea/Vomiting
☐ Ringing in Ears	☐ Diabetes	☐ Sensitivity to Light	☐ Hypertension	☐ Loss of Concentration
☐ Arthritis	☐ Memory Problems	☐ Loss of Balance	☐ Headaches	☐ Neck/Back Pain
☐ Stiffness/Flexibility	☐ Pain in Arms/Legs	☐ Sinus Troubles/Allergies	☐ Irritability	☐ Cold Hands/Feet

☐ Other_____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Is there anything else regarding your current condition you feel the doctor should know? _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this 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 is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or 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 innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a 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 innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

CONSENT TO CARE

I do hereby authorize the doctors of Justice Family Chiropractic PLLC to administer such care that is necessary for my particular case. This care may include consultation(s), examination(s), spinal adjustments and other chiropractic procedures, including Insight scanning and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. I understand that all examination procedures, including x-rays, are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Furthermore, I authorize and agree to allow the Daniel Justice D.C. and Lindsay Justice D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor(s) of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18: Parent's signature)*

FINANCIAL INFORMATION

I understand that all services rendered are my financial responsibility. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Justice Family Chiropractic will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. I also understand that if my insurance company requires pre-authorization of services or review of medical notes, that Justice Family Chiropractic will provide required documentation to my insurance company but I am financially responsible if my insurance chooses not to cover rendered services. Any monies received will be credited to my account. I certify that if this office visit is related to any personal injury or worker's compensation case that is active or that has not been closed I have noted this above.

Signature_____ Date _____
(If under age 18) Parent's signature

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1) The right to review the notice prior to signing this consent,
2) The right to object to the use of my health information for directory purposes, and
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: Date:

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

_____
_____
_____