Patient Name_____ Date: _____

New Practice Member Forms
Pediatric (0 – 7 yrs)

Name of Child_____ Date of Birth____/____/____ Age____ Male/Female

Birth Height_____ Birth Weight_____ Current Height_____ Current Weight_____

Address_____City_____State_____ Zip_____

Mother's Name_____ Date of Birth____/____/____

Mother's Phone_____ Email:_____

Father's Name_____ Date of Birth____/____/____

Father's Phone_____ Email_____

Pediatrician / Family MD_____ City/State_____

Last Visit Date____/____/____ Reason for Visit_____

Who is responsible for this bill?_____

Mother's Social Security #_____-_____-_____ Father's Social Security #_____-_____-_____

Mother's Driver's License #_____ Father's Driver's License #_____

Other_____

Who may we thank for referring you? _____

Health Conditions

Please identify the health concern(s) that brought you into this office:

Purpose of this visit: ____Wellness Check Up ____Injury or Accident ____Other

Please explain_____

If your child is experiencing pain/discomfort, please identify where and for how long:_____

_____

1. When did the problem first begin? Date____ / ____ / ____ ___Unknown __Gradual ___Sudden

2. Has this problem occurred before? ___No ___Yes, when?_____

3. Any bowel or bladder problems since this problem began? ___No ___Yes, describe:_____

_____

4. Have you seen any other doctors for this problem? ___No ___Yes, whom:_____

5. How long ago? ___Days ___Weeks ___Months ___Years

6. What were the results of past treatments?_____

7. How is this problem NOW?

___Rapidly Improving ___Improving Slowly ___About the Same ___Gradually Worsening ___On & Off

8. Please list any medication(s) taken for this problem:_____

Patient Name _____ Date_____

9. Has your child ever sustained an injury playing organized sports? ___No ___Yes, please explain:

_____

10. Has your child ever sustained an injury in an auto accident? ___No ___Yes, please explain:

_____

Has Your Child Suffered From? *(Please check ALL that apply)*

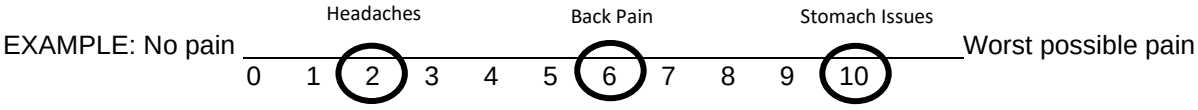
○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Leg Problems	○ Reflux	○ Muscle Pain	○ Seizures/Convulsions
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Backaches	○ Diarrhea	○ Asthma	○ Chronic Earaches
○ Sinus Trouble	○ Poor Posture	○ Hypertension	○ Walking Trouble
○ Scoliosis	○ Anemia	○ Colds/Flu	○ Sleeping Problems
○ Bed Wetting	○ Colic	○ Broken Bones	○ Fall off monkey bars
○ Fall from crib	○ Fall down stairs	○ Fall in baby walker	○ Fall from bed or couch
○ Fall off bicycle	○ Fall from high chair	○ Fall off slide	○ Fall from changing table
○ Fall off swing	○ Fall off skateboard/skates		

○ Allergies to:_____

○ Other: _____

Quadruple Visual Analogue Scale

Instructions: Please circle the number that best describes the question being asked.
Note: If there is more than one complaint, answer each question for each individual complaint and indicate the score for each. Please indicate pain level right now, average pain, and pain at its best and worst.



1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE 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?)

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?)

0 1 2 3 4 5 6 7 8 9 10

Patient Name _____ Date_____

Pregnancy Information:

How was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy? _____

Other information _____

Delivery Information:

Location of Birth: (circle one) Hospital Birth Center Home

Birth Intervention: (circle one) Forceps Vacuum Extraction Caesarian Section

Other _____

Were you induced? Yes / No (circle one)

If yes, please explain_____

Medications during delivery? _____

Other information _____

Birth Information for Child:

Breast Fed: ___No ___Yes, how long?_____ Formula Fed: ___No ___Yes, how long?_____

Introduced Solid Foods at _____ Months

Food Allergies or Intolerances _____

Doses of Antibiotics / Prescription Drugs child has taken: Past 6 months_____ Total lifetime _____

Current Information:

List all Surgical Operations & Years:

_____

_____

Adjusted Life Chiropractic Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Adjusted Life Chirpractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

Patient Name _____ Date_____

Authorization to Consent to Treatment

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, _____authorize the following individual(s),

(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

_____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

_____

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____ Parent's Name: _____

Daytime Phone: _____ Daytime Phone: _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

_____ _____

Signature of Parent or Legal Guardian Date

Patient Name _____ Date_____

REGARDING: X-rays / Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

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-rays in our files. **The fee for copying your x-rays on a disc is $10.00.** This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Adjusted Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

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

Print Name _____ Date of Birth _____

Signature _____ Date _____

Patient Name _____ Date_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). 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 and indirectly. 2. Obtain payment from third-party payers. 3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

Adjusted Life Chiropractic

I hereby authorize payment to be made directly to Adjusted Life 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 Adjusted Life Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

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

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**