



Name (Legal): _____ Preferred Name: _____

Age: _____ Date of Birth: _____

Current Height: _____ Current Weight: _____

Address: _____ Zip Code: _____

Email: _____

Mother's Name: _____ Mother's Phone: _____

Father's Name: _____ Father's Phone: _____

Person Financially Responsible for Account (Parent/ Guardian) _____

Name of person(s) we can discuss your care/account with (name, relationship) _____

Has your child ever been under chiropractic care before? Y / N _____ Clinic/Doctor's Name: _____

Who can we thank for referring you or how did you hear about us? _____

PRENATAL/BIRTH HISTORY

Was there any difficulties getting pregnant? _____ Fertility Treatments: Y N _____

Was there any complications or unusual stressors during the Pregnancy or Labor/Delivery? _____

Please list any Medications that were taken during pregnancy? _____

Was there any Cigarette/Alcohol use during pregnancy? Y N _____

Position of Baby in Third Trimester (Circle One) Breech Transverse Face/Brow Head Down

How far along were you at time of birth? Weeks Day

Circle any applicable Interventions: Pitocin Epidural Episiotomy Forceps/Vacuum C-section Antibiotics

How long was your entire labor? Pushing?

Was the delivery an emergency? Y N If yes, please explain: _____

Was there presence of? Jaundice (Yellow) Cyanosis (Blue) Congenital Anomalies/Defects: _____

If yes, please explain: _____

Child's Birth Weight: _____

Did your child require additional hospitalization? _____

INFANT HISTORY

Infant feeding (Circle One): Breast Bottle

Did your child have any difficulty with latching or sucking? Tongue Tie? Y N

Number of hours of sleep per night: Quality of Sleep: Good Fair Poor

Has your child ever been hospitalized?

Please list any surgeries your child has had:

Please list any medications your child has taken or is currently on:

Please list any allergies your child has:

DEVELOPMENTAL HISTORY:

Please tell us about your child's development? Were there any struggles?

Does your child tend to fall frequently?

Is/has your child been involved in any sports?

Has your child sustained an injury playing sports or from falls?

Has your child ever been involved in a car accident?

CURRENT HEALTH GOALS:

Purpose of this visit:

When did this begin?

Has the child had this before? Y N If yes, when?

Have you seen any other Providers for this ? Y N Clinic/Doctor's Name:

If we could help your child achieve/improve three things, what would they be?

1) _____ 2) _____ 3) _____

What would you like to gain from chiropractic care? (Please Circle One)

Resolve Existing Condition Enhance How Their Body Functions Both

Check any of the following symptoms in which your child has now (N) or in the past (P):

- | <u>N</u> | <u>P</u> | | <u>N</u> | <u>P</u> | |
|----------|----------|-----------------------------|----------|----------|-------------------------------|
| ___ | ___ | Colic & Excessive Crying | ___ | ___ | Epilepsy & Seizures |
| ___ | ___ | Torticollis & Plagiocephaly | ___ | ___ | Sensory & Spectrum Issues |
| ___ | ___ | Sever or Frequent Headaches | ___ | ___ | ADD/ADHD |
| ___ | ___ | Ear or Sinus Infections | ___ | ___ | Focus & Memory Issues |
| ___ | ___ | Headaches & Migraines | ___ | ___ | Anxiety & Stress |
| ___ | ___ | Vertigo or Dizziness | ___ | ___ | Balance & Coordination Issues |
| ___ | ___ | Vision or Hearing Issues | ___ | ___ | Speech Challenges |
| ___ | ___ | TMJ/Jaw Pain | ___ | ___ | High or Low Blood Pressure |
| ___ | ___ | Frequent Colds | ___ | ___ | Reflux/ GERD |
| ___ | ___ | Difficulty Sleeping | ___ | ___ | Depression |
| ___ | ___ | Croup or Chronic Cough | ___ | ___ | Swollen Tonsils & Adenoids |
| ___ | ___ | Sore Throat & Strep | | | |

UPPER/MID THORACIC:

- | | | | | | |
|-----|-----|-------------------------|-----|-----|-----------------------------|
| ___ | ___ | Chronic Colds & Cough | ___ | ___ | Blood sugar problems |
| ___ | ___ | Asthma | ___ | ___ | Rapid or slow beating heart |
| ___ | ___ | Bronchitis or Pneumonia | ___ | ___ | Chest pain |
| ___ | ___ | Immune Deficiency | ___ | ___ | Difficulty breathing |
| ___ | ___ | Gallbladder Pain/Issues | ___ | ___ | Indigestion or Heartburn |
| ___ | ___ | Fevers | ___ | ___ | Stomach Pain or Ulcers |
| ___ | ___ | Liver trouble | ___ | ___ | High or Low blood pressure |

LOWER THORACIC:

- | | | | | | |
|-----|-----|-------------------------------|-----|-----|------------------------|
| ___ | ___ | Excessive Stress & Cortisol | ___ | ___ | Allergies or Eczema |
| ___ | ___ | Hyperactivity | ___ | ___ | Skin Conditions & Rash |
| ___ | ___ | Chronic Fatigue or Low energy | ___ | ___ | Kidney Problems |
| ___ | ___ | Poor Metabolism | ___ | ___ | Gas Pain or Bloating |
| ___ | ___ | Behavioral Issues | | | |

LUMBAR:

- | | | | | | |
|-----|-----|----------------------|-----|-----|------------------------------|
| ___ | ___ | Constipation | ___ | ___ | Bedwetting |
| ___ | ___ | Crohn's/ IBS/Colitis | ___ | ___ | Cramps or menstrual problems |
| ___ | ___ | Constipation | ___ | ___ | Painful urination |
| ___ | ___ | Diarrhea | ___ | ___ | Bladder or Urination Issues |

TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

I, (Parent/ guardian) _____ hereby consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Nicholas Centra, Dr. Tara Centra and staff who now or in the future may treat my child while employed by this office. I will have an opportunity to discuss with Centra Family Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Centra Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my child's health history is correct to the best of my knowledge. I will not hold the doctor or any staff member of Centra Family Chiropractic responsible for any errors or omission that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read, or have had read to me, the full above terms of acceptant and consent to chiropractic services and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff. I have also read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Parent/Guardian Signature: _____

Date: _____

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. And, that Centra Family Chiropractic does not take any insurance. I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the case of a pre-pay plan, payments made for services not utilized will be returned.

Parent/Guardian Signature: _____

Date: _____

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the circle that applies to you:

- Sure! You can use my picture on the CFC website, FB page, and/or other social media posts as long as I look good!
- No thanks! I'll pass for now

Parent/Guardian Signature: _____

Date: _____
