Family Chiropractic Center
20700 Chippendale Ave Ste 7
Farmington, MN 55024
651-460-9449

ABOUT THE PEDIATRIC PATIENT

Today's Date _____

Name _____ Birthdate _____ Age_____ Gender_____

Parent/Guardian Names _____ _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail Address _____

Emergency Contact _____ Ph # _____

Has your child been to a chiropractor before? □ No □ Yes If Yes, Where? _____

When was the last time the child was adjusted? _____ What type of care was received? ❑ Acute ❑ Wellness ❑ Both

How did you hear about us? _____ Whom may we thank for referring you? _____

Pediatrician _____ Clinic _____

Other Current Health Provider _____ Clinic _____

REASON FOR SEEKING CARE

Chiropractic care can help kids with issues beyond pain. Common childhood complaints are listed below. Does your child struggle with any of the following?

Past	Present		Past	Present	
❑	❑	ADD | ADHD	❑	❑	Flattened Head
❑	❑	Allergies: Food | Seasonal | Pet	❑	❑	Growing Pains
❑	❑	Anxiety | Depression	❑	❑	Headaches
❑	❑	Asthma	❑	❑	Medication Side Effects
❑	❑	Autism Spectrum	❑	❑	Neck | Back Pain
❑	❑	Bed Wetting	❑	❑	Picky Eater
❑	❑	Chronic Colds/Sinus Infections	❑	❑	Recurring Fevers
❑	❑	Colic	❑	❑	Reflux | GERD
❑	❑	Constipation | Diarrhea	❑	❑	Scoliosis
❑	❑	Croup	❑	❑	Seizures
❑	❑	Dental Problems	❑	❑	Sensory Processing
❑	❑	Difficulty Nursing	❑	❑	Sleeping Problems
❑	❑	Digestive Problems	❑	❑	Sport Injuries
❑	❑	Ear Infections	❑	❑	Temper Tantrums
❑	❑	Eczema | Skin Rashes	❑	❑	Vision Problems
❑	❑	Other _____			

Doctor's Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

1. _____

How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb/Tingle ❑ Stabbing ❑ Constant ❑ Intermittent

❑ Pain radiates to_____

This affects: ❑ Sleep ❑ School ❑ Daily Routine ❑ Sitting ❑ Activities

❑ Other: _____

Treatment received? _____ Results? _____

2. _____

How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb/Tingle ❑ Stabbing ❑ Constant ❑ Intermittent

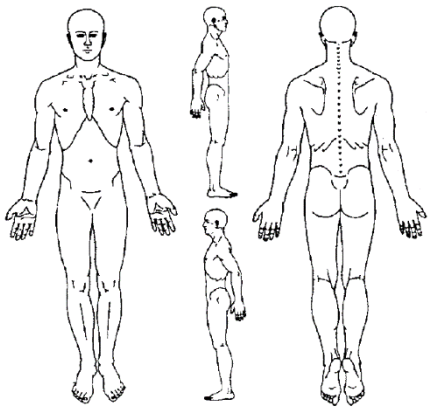
❑ Pain radiates to_____

This affects: ❑ Sleep ❑ School ❑ Daily Routine ❑ Sitting ❑ Activities

❑ Other: _____

Treatment received? _____ Results? _____

Please mark all areas of concern



PAST HEALTH HISTORY

For Infants: ❑ Breast Fed ❑ Trouble Latching ❑ Breast Preference
❑ Breast Milk / Bottle Fed
❑ Formula: What Brand? _____
Name of Obstetrician/Midwife: _____

Complications during pregnancy? ❑ No ❑ Yes Please explain: _____
Did you have ultrasounds during pregnancy? ❑ No ❑ Yes How many? _____
Medications during pregnancy? ❑ No ❑ Yes Please list: _____
Cigarette\Vape use during pregnancy? ❑ No ❑ Yes Alcohol use during pregnancy? ❑ No ❑ Yes

Birth Information: ❑ Vaginal ❑ C-Section ❑ V-BAC at ❑ Hospital Birth ❑ Mid-Wife ❑ Home Birth ❑ Birth Center
Was there any complications during birth? ❑ No ❑ Yes Please explain: _____
_____

Has the child been on antibiotics? ❑ No ❑ Yes How many times? _____ Did they use probiotics afterwards? ❑ No ❑ Yes
List any past sport, recreational, or home injuries: _____
Has your child had any concussions? ❑ No ❑ Yes How many? _____
Please list any past hospitalizations and surgeries: _____
_____
Does your child have any medical devices in their body (pacemaker, metal plates, surgical screws, etc)? _____
List any medications your child is taking: _____

List any past auto collisions: _____ Date_____
Was any care received, if so where? _____
Continued complaints as a result? _____

CARE GOALS

I am looking to get: ❑ Acute care only ❑ Pain relief and wellness care ❑ Continue with wellness care

Goals for care are: 1. _____
2. _____
3. _____

What impact have your child's complaints had on their lifestyle and activities? _____
_____

We offer multiple therapeutic services at our clinic. Please indicate if you are interested in learning more about:

❑ Acupuncture ❑ Massage ❑ Laser ❑ TheraMat ❑ Supplements

We want to respect your schedule and budget when building a custom care plan. Are there any considerations of monthly budget you would like us to be aware of? ❑ No – Build the plan that my child needs to meet the goals listed above

❑ Yes – I would like to stay within a monthly budget of: ❑ Under $100 ❑ $100 - $200 ❑ $200 +

Are there any considerations you want us to know regarding your schedule and availability for appointments? _____
_____

AUTHORIZATION

- I authorize the doctor or staff to render care as deemed appropriate for me and/or my child.
- I authorize Family Chiropractic Center to release and/or request records to or from other providers as may be necessary.
- I hereby certify that the information provided is true and accurate.

Patient/Guardian Signature _____ Date_____

Doctor Signature _____ Date_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in the symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. The options may include, but are not limited to: self-administered care, over-the-counter pain relievers physical measures and rest, medical with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient/Guardian Name _____ Date _____

Signature _____

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 begin any health care operations we must require you to read and sign this form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

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 affect 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 all take precautions that are known by this office to assure that your re cords 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, the chiropractic physician has the right to refuse to give care.

8. The patient understands and agrees to allow this office to use their name and images for newsletters (both mailed and emailed), social media posts and ads, birthday cards, patient testimonials, referrals, appointment reminder calls and/or mailings, use of photos, and reactivation calls and/or mailings.

The patient understands that under the Health Insurance Portability and Accountability Act (HIPAA), the patient has certain rights to privacy regarding my protected health information. The patient acknowledges that he or she has received or has been given the opportunity to receive a copy of their Notice of Privacy Practices. The patient also understands that this practice has the right to change its Notice of Privacy Practices and that the patient may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Name _____ Date _____

Signature _____

Paying for care is easy! Mark which one works best for you:

_____ **Custom Care Plan**: Our care plans and simple payment arrangements have helped over 5,000 people and are sure to work great for you too! These days, insurance pays very little for natural, drugless care to get you healthy which is why we don't accept commercial insurance. Our custom care plans have budget-friendly payment options which are discussed prior to starting care. We will **never** surprise you with a bill in the mail! Don't worry, you can still use your HSA or FSA dollars here!
_____ **Auto Injury:** Auto-related injuries are covered at 100% in MN - even if you were at-fault or were a passenger! You can get the care you need; we'll take care of the rest! Your insurance even covers Acupuncture, Massage, and Laser! _____ **Initial:** *By initialing here, you understand that you may be responsible for a* ***$95 no show/$45 late cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 24 hours if a cancellation is necessary****.*
_____ **Work Injury:** Work injuries are covered at 100% for up to 12 weeks of treatment. You can get the care you need; we'll take care of the rest! Your insurance even covers Acupuncture, Massage, and Laser! _____ **Initial:** *By initialing here, you understand that you may be responsible for a* ***$95 no show/$45 late cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 24 hours if a cancellation is necessary****.*
_____ **Medicare:** Regardless of your condition, Medicare pays for **active care** adjustments only. They have very strict rules and limitations. Medicare examinations are required to show you are eligible for care, but Medicare does NOT cover them ($50). Maintenance care is not a covered service through Medicare, but we offer a special rate of $42/visit for Medicare patients.

For Your Convenience*:*

We like to make things as easy as possible for our patients - including paying for care! Prior to beginning treatment, we will go over all costs anticipated with your customized plan. Feel comfortable knowing we use a secure portal to hold your credit card information.

- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- The clinic may use photos/images for promotional materials and posts.
- If your account becomes 30 days past due, we will run the card on file for the outstanding balance.
- If you chose to discontinue care before your plan has been completed, an account reconciliation will be performed. A payment or credit (via check) will be issued.

Patient/Guardian Name _____ Date _____

Signature _____