BALANCE CHIROPRACTIC

PEDIATRIC HEALTH HISTORY

Child's Name: _____ Birth Date: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Parent's/Guardians' Name: _____

Home Address: _____ City: _____ State: _____

Zip: _____ Parent's Email: _____

Parent's Cell Phone: _____ May we leave a message? Yes No

Parent's Work Phone: _____ May we leave a message? Yes No

Siblings and ages: _____

How did you hear about us? _____

Has your child ever been under Chiropractic Care? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to child: _____

Phone Number: _____ Alternative phone number: _____

Family Doctor

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

May we communicate with your family doctor regarding your child's care if necessary? Yes No

Why have you decided to have your child evaluated by a Chiropractor?

- ❑ He/She is continuing care from another chiropractor.
- ❑ I recently had my spine checked and understand the value in getting my child checked.
- ❑ I have concerns about his/her health and I'm looking for answers.
- ❑ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ❑ I want to improve my child's immune function.

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive
☐	☐	Respiratory Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling/Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Back Pain	☐	☐	Sleep Problems
☐	☐	Frequent sickness	☐	☐	Growing Pains	☐	☐	Concentration Problems
☐	☐	Recurrent Fevers	☐	☐	Torticollis/Head Tilt	☐	☐	Tie Toe Walking
☐	☐	Eczema	☐	☐	Trouble feeding on one side	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joints	☐	☐	Tremors/ Ticks
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD/ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying	☐	☐	Autism

Do you have a specific concern that brings you in?

- ❑ No, I would like my child's nervous system assessed to achieve optimal health & functioning.
- ❑ Yes: _____

_____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ When did it start? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint? ☐ Yes ☐ No

If Yes, Whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes: _____

Has your child ever experienced this complaint before? ☐ No ☐ Yes: _____

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: _____

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center Other: _____

Medications during labor/delivery (including IV antibiotics): ☐ No ☐ Yes: _____

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Was your child at any time during pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? ☐ Vaginal ☐ C-Section: Planned or emergency?

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other: _____

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: _____

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes: _____

Any concerns about misshapen head at birth? ☐ No ☐Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

Was the baby ever admitted to the NICU? ☐ No ☐ Yes

If yes, for how long and why? _____

Were there any medications given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ☐ No ☐ Yes: How many months: _____

Was your child breastfed + formula fed? ☐ No ☐ Yes: How many months: _____

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

Has your child been vaccinated? ☐ No ☐ Yes

If yes, ☐ Full ☐ Partial ☐ Delayed ☐ Other: _____

Did your child have any reactions to vaccines? ☐ No ☐ Yes: _____

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes

Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes

Has your child broken any bones? ☐ No ☐ Yes

Has your child had any previous hospitalizations? ☐ No ☐ Yes

Has your child had any previous surgeries? ☐ No ☐ Yes

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly

Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No: _____

Emotionally: ☐ Yes ☐ No: _____

Physically: ☐ Yes ☐ No: _____

What is your primary goal for your child in this office?

_____

_____

Our goals are to provide a detailed assessment of your child's current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain — 0 1 (2) 3 4 (5) 6 7 (8) 9 10 — **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain — 0 1 2 3 4 5 6 7 8 9 10 — **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain — 0 1 2 3 4 5 6 7 8 9 10 — **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain — 0 1 2 3 4 5 6 7 8 9 10 — **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain — 0 1 2 3 4 5 6 7 8 9 10 — **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care. Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

Practice Member Information (Must be Completed before Services Can Be Rendered)

NAME: _____

FIRST MIDDLE LAST

PHONE: Home: _____ Cell: _____ Work: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation-**includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and /or static palpation, leg checks $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-Rays-**Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can be used to indicate progress after a period of care. $50 per view.
-

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Erin Magee, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ Date_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____
PRINT PATIENT'S NAME HERE

_____ _____
PATIENT'S SIGNATURE DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. ERIN MAGEE AND ANY AND ALL BALANCE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY BALANCE CHIROPRACTIC.

_____ _____
DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR /CHILD

_____ _____
WITNESS SIGNATURE (OFFICE STAFF) DATE

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedures applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (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 (HIPAA). 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 PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request is used to disclosed 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)

PLATINUM ID

X-RAY AUTHORIZATION FOR MINOR/CHILD

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 AND VIDEO FLUOROSCOPY STUDY ON A DISC IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON AND REGULAR PRACTICE HOUR DAYS.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF PROVIDENCE CHIROPRACTIC DO 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 ADVISE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT PATIENT'S NAME HERE

PATIENT'S DATE OF BIRTH

GUARDIAN SIGNATURE & RELATIONSHIP TO CHILD/MINOR

DATE

ADOLESCENT FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE SHE IS NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT PROVIDENCE CHIROPRACTIC.

SIGNATURE

DATE

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐F

☐Lat Cervical ☐Flex/Ext

CM	Kvp	Time	MAS
☐6-7	☐68	☐1/24	3
☐8-9	☐70	☐1/20	5
☐10-11		☐1/15	10
☐12-13		☐1/10	12.5
☐14-15		☐2/15	15

MA 300 Size 8x10

☐Cervico-Thoracic

CM	Kvp	Time	MAS
☐6-7	☐70	☐1/10	3
☐8-9	☐80	☐2/15	5
☐10-11		☐3/20	7
☐12-13		☐2/10	10
☐14-15			

MA 300 Size 8x10

☐APOM

CM	KVP	Time	MAS
☐14-15	☐70	☐1/10	10
☐16-17		☐2/15	15
☐18-19		☐3/20	20
☐20-21		☐2/10	30
☐22-23			

MA 300 Size 8x10

Other View _____

CM _____ Kvp_____

MAS _____ MA _____

Size _____

☐Lateral Thoracic

CM	KVP	Time	MAS
☐16-17	☐80	☐1/15	5
☐18-19		☐1/10	10
☐20-21		☐2/15	20
☐22-23		☐2/10	30
☐24-25		☐1/4	40
☐26-27		☐3/10	50
☐28-29		☐2/5	75
		☐1/2	90

MA 300 Size 14x17

☐A-P Thoracic

CM	KVP	Time	MAS
☐8-9	☐75	☐1/20	5
☐10-11	☐80	☐1/15	10
☐12-13		☐1/10	17
☐14-15		☐2/15	22
☐16-17		☐2/10	30
☐18-19		☐1/4	40
☐20-21		☐3/10	50
☐22-23		☐2/5	75

MA 300 Size 14x17

☐Lateral Lumbar

CM	KVP	Time	MAS
☐18-19	☐80	☐2/10	3
☐20-21	☐90	☐1/4	5
☐22-23		☐3/10	7
☐24-25		☐2/5	30
☐26-27		☐1/2	40
☐28-29		☐3/5	50
☐30-31		☐4/5	60
☐32-33		☐1	75
☐34-35		☐1 1/5	80
☐36-37		☐2	

MA 200 Size 14x17

☐A-P Lumbar

CM	KVP	Time	MAS
☐10-11	☐76	☐1/15	3
☐12-13	☐78	☐1/10	5
☐14-15	☐80	☐2/15	7
☐16-17		☐2/10	40
☐18-19		☐1/4	50
☐20-21		☐3/10	75
☐22-23		☐2/5	90
☐24-25		☐1/2	
☐26-27		☐3/5	
☐28-29		☐4/5	
☐30-31		☐1	
☐32-33		☐1 ½	
		☐2	

MA 200 Size 14x17

Fluoro: 0.25 - _____MA; _____ - _____ kvp; _____secs

Notes: _____

_____

_____

_____

CA Initials _____