CHiLD PRACTiCE MEMBER FoRM

AUTHORITY CHIROPRACTIC

OFFICE USE ONLY

C
L
T
ABR

ID#
INS
Y/N

PERSONAL INFORMATION

Child's Name : Gender: Male Female

Address :

Date of Birth : / / Age: Current Height & Weight:

Mother's Name: Mother's Date of Birth : / /

Mother's Mobile: Mother's Last 4 SSN: Father's Mobile:

Father's Name: Father's Date of Birth : / /

Pediatrician/Family MD: City/State:

Last Visit: / / Reason For Last Visit:

Who may we thank for referring you?

PURPOSE OF THIS VISIT

What health concerns bring you into our office? Wellness Checkup Injury or Accident Other:

Please explain:

Have you received care for this problem before? Yes No - If yes, when?

If Yes: Chiropractor Medical Doctor Other:

If Yes: Who? Results?

How did the problem(s) start? Suddenly Gradually Post-Injury

This condition is: Getting Worse Improving Intermittent Constant Unsure

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

Please list any medications your child takes and for what reason:

Has your child ever sustained an injury playing organized sports? Yes No If yes, please explain:

Has your child ever sustained an injury in an auto accident? Yes No If yes, please explain:

Was your child born before 40 weeks gestation? ○ Yes ○ No If yes, please explain:

My child was born: ○ Vaginal Birth ○ Cesarean/C-Section

Did your child sustain any trauma during labor/delivery? ○ Yes ○ No If yes, please explain:

Covid Vaccine? ○ Yes ○ No

Other vaccine history: ○ Fully ○ Partially ○ No Vaccines

HAS/DOES YOUR CHILD SUFFER FROM: *Check all that apply*

Past	Current	
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Seizures/Convulsions
☐	☐	Heart Trouble
☐	☐	Chronic Earaches
☐	☐	Sinus Trouble
☐	☐	Scoliosis
☐	☐	Bed Wetting
☐	☐	Fall from bed or couch
☐	☐	Fall from high chair
☐	☐	Behavioral Problems
☐	☐	ADD/ADHD
☐	☐	Ruptures/Hernia
☐	☐	Muscle Pain

Past	Current	
☐	☐	Orthopedic Problems
☐	☐	Neck Problems
☐	☐	Arm Problems
☐	☐	Leg Problems
☐	☐	Joint Problems
☐	☐	Backaches
☐	☐	Poor Posture
☐	☐	Anemia
☐	☐	Broken Bones
☐	☐	Fall from crib
☐	☐	Fall from changing table
☐	☐	Growing Pains
☐	☐	Asthma
☐	☐	Hypertension
☐	☐	Sleeping Problems

Past	Current	
☐	☐	Digestive Disorders
☐	☐	Poor Appetite
☐	☐	Stomach Ache
☐	☐	Reflux
☐	☐	Colic
☐	☐	Latching/Feeding Difficulty
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Colds/Flu
☐	☐	Fall down stairs
☐	☐	Fall off slide/playground
☐	☐	Walking Trouble
☐	☐	Fall in baby walker
☐	☐	Fall off bicycle

☐ Other:

Please list any allergies:

Notes:

PAIN SCALE *Please complete for your child if applicable. (For reference, 0 = no pain and 10 = worst possible pain.)*

How would you rate your child's pain right now?

What is their typical or AVERAGE pain?

What is your child's pain level at its BEST? (How close to 0 does your child's pain get at its best?)

What is your child's pain level at its WORST? (How close to 10 does your child's pain get at its worst?)

ACKNOWLEDGEMENT

I understand that I am directly and fully responsible to Authority Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse, or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

PRINT NAME:

SIGNATURE: **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.

Prior to receiving chiropractic care in the 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 recommended, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a plan of care 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.
- I authorize and request payment of insurance benefits directly to Authority Chiropractic. 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 practice member. 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.

PRINT NAME:

SIGNATURE: **DATE:**

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of practice member who is a minor/child:

I authorize doctors of Authority Chiropractic 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. If my authority to select and authorize care is revoked or altered, I will immediately notify Authority Chiropractic.

GUARDIAN SIGNATURE: **DATE:**

RELATIONSHIP TO MINOR/CHILD:

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 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 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:** __________

I authorize Authority Chiropractic to discuss my medical records with the following individuals:

____

X-Ray Authorization

X-rays are utilized in this office to analyze structural changes of the spine. Authority Chiropractic does not diagnose or treat medical conditions; however if any abnormalities outside the realm of chiropractic are found, we will bring it to your attention so that you can seek proper medical advice. Digital X-rays may be copied onto a CD if requested. Please allow up to 72 hours for copies to be made. Authority Chiropractic reserves the right to charge a $10 fee for copying these films.

PRINT NAME: __________ **DATE OF BIRTH:** __________

SIGNATURE: __________ **DATE:** __________

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Authority Chiropractic.

SIGNATURE: __________ **DATE:** __________