Waccamaw Chiropractic & Wellness Center

DR ______________ FILE # ______________

YOUTH PATIENT INFORMATION

Patient Name: ____ DOB:__________________ Date: ________________

Parent Name: ____ Phone: ______________________________________

Address: ____ City/State/Zip:________________________________

Parent Phone: ____ Patient Phone: ________________________________

Would you like to receive EMAIL or TEXT reminders? YES (EMAIL OR TEXT) NO

Whom may we thank for referring you? ____

Responsible for Financials ❒ Patient ❒ Parent ❒ Health Insurance ❒ Other__________________

Insurance Company AND Member #: ____

1. Has your child previously benefited from chiropractic care? ❒ Yes ❒ No

   If yes, when and where was their last visit? ____

2. Purpose of this appointment: ❒ Periodic Spinal Analysis / Wellness ❒ Specific Concern

   Explain:____

3. When did this condition begin? ____

4. Other treatment received for this condition which did not work: ____

5. Does this condition affect the quality of your child's:

   ❒ Relationship with friends/family ❒ Enjoyment of sports/hobbies ❒ Is the condition is getting worse

6. Are there any special circumstances which may be causing your child extra emotional stress?

   ❒ No ❒ Yes (ie. divorce, illness in the family, etc.) ____

7. Circle Appropriately:

   Birth Place: Home / Hospital / Birth Center

   Type: Vaginal / C-Section

   Procedures: Forceps / Vacuum / Extraction

   Labor: Natural Progression / Induced

8. Circle Appropriately:

   In which contact sport does your child participate?

   Soccer / Football / Karate / Gymnastics / Hockey

   Dance / Basketball / Wrestling / ______________________

8. According to the National Safety Council, approximately 50% of infants fall head first from a high place

   (ie. bed, changing table, etc.) during the first year of life. If this has happened to your child, please explain:

   ____

9. Circle any of the following conditions your child has suffered from during the past six months:

Asthma/Allergies	Seizures	Recurring Fevers	Scoliosis	Chronic Colds	ADHD
Digestive Problems	Headaches	Bed Wetting	Colic	Temper Tantrums	Car Accident
Learning Disabilities	Ear Infections	Growing/Back Pain		Other______________________________	

10. Number of Siblings: _______ Do any suffer from similar health problems? _______________________________________

11. How many <u>antibiotic prescriptions</u> has your child taken in the past six months? ________ Total in lifetime? ____________

12. How many other <u>prescription medications</u> has your child taken during the past six months? _____ Total in lifetime? _____

13. How many <u>over-the-counter medications</u> has your child taken during the past six months? ______ Total in lifetime? _____

14. Has your child ever: ❒ Been Hospitalized ❒ Had Surgery ❒ Emergency Room Visit

    If yes, please explain ____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: ____ Date: ______________________________________

CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, diagnostic x-rays, and nutritional products on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors at Waccamaw Chiropractic and Wellness Center.

I understand that nutritional information or suggestions are not intended to diagnose, cure, or prevent disease. Nutritional supplement are used to support normal body function.

I have had the opportunity to discuss with the doctor and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctors to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then knowing, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover entire course of treatment.

I authorize payment directly to the doctor from my insurance company and I clearly understand that I am responsible for payment should my insurance company deny payment or make payments directly to me. I understand the initial visit fees are due and payable at the time of service.

To be completed by patient:

______________________________________ X ______________________________________ ____________________

Print Your Name | Signature | Date

If patient is a minor or physically or legally incapacitated. To be completed by Patient's Representative:

______________________________________ X ______________________________________ ____________________

Print Name of Patient's Representative | Signature of Patient's Representative | Date

As: ____

Relationship or Authority of Patient's Representative