Phone: 405.707.3050
Fax: 405.707.3051
526 E. Lakeview Rd
www.sunrisehi.com

Confidential Client Information - Children 12 & under

Personal Information			Date:
Child's Full Name:			
Mother's Name:			
Father's Name			
Address:	City	State	Zip
Home phone:		Mom's Cell phone:	
Dad's Cell phone:		Email address:	
Social Security Number:			
Date of Birth:		Age:	
Name of person responsible for account:			
Please allow us to make a copy of your insurance card.			

Who may we thank for referring you to our office? ______________________________

Addressing What Brought You Into This Office:

What is the reason for your visit today? How long has it been going on?

____

____

Are there any other specific concerns?

____

____

1) Tell us about the pregnancy of this child

Did you carry full term? ______________________________

Describe any complications and when they occurred:

____

____

2) Tell us about the delivery and birth of this child:

Did you use a midwife? ________ Hospital? ________ Obstetrician? ________ C-Section? ________
Vacuum Extraction? ________ Were forceps used? ________ Were you induced? ________
Did you have an epidural? ________ Was it a difficult birth? ________
Baby's APGAR Score? ________ at 5 minutes? ________

3) Tell us more

Did you breastfeed? ___________ How long? __________ What formula after? ___________

Did you consume alcohol during your pregnancy? _______ How much? __________

Did you smoke? ______ How much? ________ How long? ____________

Did you take any medication during your pregnancy? __________

For what? ______________________________ What type? ______________________

Any exposure to ultrasound? ___________ How many? ____________

4) As a baby/toddler, (birth to 3 years), did any of the following occur?

___ Fall from a changing table	___ Tonsilitis	___ Tumble down stairs	___ Reaction to vaccination
___ Frequent bouts of diarrhea	___ Frequent fevers	___ Did not gain weight	___ Frequent ear infections
___ Frequent crying spells	___ Fall out of a crib	___ Frequent Colds	___ Other ___________________
___ Involved in a car accident	___ Constipation	___ Play in a "Jolly Jumper"	
___ Colic	___ Sleeping problems	___ Fall off playground equipment	

Please explain the above: ____

____

5) As a young child, (4-9 years), did any of the following occur?

___ Fall from a tree	___ Bed Wetting	___ Stomach pains	___ Hyperactivity/Autism
___ Fall off a bicycle	___ Car accident	___ Scoliosis	___ Other ___________________
___ Leg/knee pain	___ Sports accident	___ Allergies	
___ Learning difficulties	___ Asthma	___ Fall off playground equipment	

Please explain the above: ____

____

6) Tell us about any vaccinations your child has had:

____

____

Any reactions to any of these? ____

____

Were you told that you had a choice in vaccinating your child? ___ YES ___ NO

Would you like information on the "other side" of this issue? ___ YES ___ NO

7) As a child or adolescent, (10-12 years), has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Arm/wrist pains	___ Fatigue
___ Dizziness	___ Foot/ankle/knee pains	___ Allergies	___ Weight gain/loss
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains	___ Other _______________
___ Asthma	___ Tingling in arms/legs	___ Shoulder pains	
___ Hyperactivity	___ Stomach problems	___ "Growing Pains"	

Please explain the above: ____

____

Since the problem started is it: About the same? O Getting better? O Getting worse? O

What have you done for this condition? Did it help? ____

____

I do/do not have a family history of this or similar symptoms (Please explain): ____________________

____

Which activities aggravate your child's condition? ____________________

____

Have you been "forced" or "felt the need" to make any "positive" changes in your child's life due to this pain, illness, condition? ____________________

____

Is this condition interfering with any of the following? (Please explain)

Work O Sleep O Daily Routine O Sports/Exercise O Other O

General Health History

Has your child had any surgery? (Please include all surgeries)

Type:	When:	Doctor:
Type:	When:	Doctor:

Has your child been in any accidents or had any injuries?

Type:	When:	Hospitalized? Yes O No O
Type:	When:	Hospitalized? Yes O No O

Has your child ever had x-rays taken?

Area of body:	When?	Where?
Area of body:	When?	Where?

Does your child wear orthotics or heel lifts? Yes O No O

Current Medicines and Supplements

Please list any supplements, vitamins, and/or medications/drugs/antibiotics your child has taken in the past 6 months and why: (prescription and non-prescription)

____

____

Is there anything else which may help us to better understand your child, which has not been discussed?

____

____

Our Fee Structure

Consultation	Complimentary
Examination	$100.00
Infant Exam	$40.00
Adjustment	$60.00

Please Note: If you and the provider decide this is the place for your child to be, then your child will receive an adjustment on the first visit which will be an additional fee. The clinical Report of Findings, the time the provider spends with you to go over your child's results will be included with the examination fee. Your child will receive an adjustment after the Report of Findings which will be a separate fee.

Insurance and Payment Policy

We are committed to providing you with the best possible care. If you have Chiropractic coverage in your insurance policy, we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment Policy:

1) Full payment is due at the time of service. We accept cash, checks, Visa, MasterCard, and Discover.

2) We must emphasize that our relationship is with you and not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract; therefore, we do not file your insurance for you. As a courtesy that we extend to our patients, we will provide you with a completed insurance form; however, you are responsible for filing it, which simply means placing it in an envelope and mailing it.

3) Not all services are a covered benefit in all contracts. It will depend on your individual policy.

4) In most cases, once you have met your deductible your insurance company will begin to reimburse you up to an allowed amount. If you have a question about your specific policy and coverage, please call the toll free number on the back of your insurance card and they should be able to answer your questions regarding your policy.

5) Medicare patients are responsible for payment at the time of service because Medicare does not cover in this office. We will not file claims to Medicare. Medicare patients will sign an Advanced Beneficiary Notice of Noncoverage stating that they understand this and they would still like to receive services.

6) In the case of a Personal Injury accident (car accident or accident at work), our policy stays the same. Payment will still be required upon time of service. All services received will be at our full price for the duration of the Personal Injury case.

There is no fee for consulting with the doctor. Fees begin when a problem related to nerve interference is found and you begin receiving care.

I fully understand the above fees and give my consent to consult with the providers and to any BioStructural examination that the provider deems necessary. I understand that any fee for service is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ Date: ____________________

Guardian Signature: ____

We sincerely thank you for choosing our office and for taking the time to honestly reflect upon and share your current level of health and well-being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!