Sunrise Health Institute

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3224 N. Perkins Rd.
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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
___ Frequent bouts of diarrhea
___ Frequent crying spells
___ Involved in a car accident
___ Colic
___ Tonsilitis
___ Frequent fevers
___ Fall out of a crib
___ Constipation
___ Sleeping problems
___ Tumble down stairs
___ Did not gain weight
___ Frequent Colds
___ Play in a "Jolly Jumper"
___ Fall off playground equipment
___ Reaction to vaccination
___ Frequent ear infections
___ Other _____

Please explain the above: _____

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

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

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

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!