Innate Chiropractic Healing Arts Center
Dr. Jackie St.Cyr, Family Wellness Chiropractor
8100 Washington Ave #210, Houston, TX 77007
(713) 521-2104 www.N8Chiro.com

Welcome to our office!

It is our pleasure to serve you today!
To help us better understand your needs, please answer the following questions:

PEDIATRIC PATIENT - CONFIDENTIAL HEALTH HISTORY

Child's First Name _____ **Middle Name** _____ **Last Name** _____

Date of Birth _____ **Age** _____ **Gender** _____

Parent/Guardian Name(s): _____

Street Address _____

City _____ **State/Province** _____ **Zip Code** _____

COMMUNICATIONS: To conserve resources, we generally utilize EMAIL and TEXT for regular communications and appointment reminders.

May we Email you?
◯ Yes ◯ No

May we Text you?
◯ Yes ◯ No

Email _____ **Cell Phone (000) 000-0000** _____

Work Phone (000) 000-0000 _____ **Home Phone (000) 000-0000** _____

Who referred you or how were you inspired to visit our office? (Please give details.)

_____

Like all the patients we care for, why did you choose our office over others in the area?

_____

CURRENT HEALTH CONCERNS FOR YOUR CHILD

Please list health concerns (reasons for seeking care here) that you have for your child and rate the severity of each from 1-10 with 10 being the worst.

CHIEF PHYSICAL CONCERNS

#1 Physical Concern _____ **Severity (1-10)** _____

#2 Physical Concern _____ **Severity (1-10)** _____

#3 Physical Concern _____ **Severity (1-10)** _____

#4 Physical Concern _____ **Severity (1-10)** _____

CHIEF EMOTIONAL CONCERNS

1st Emotional Concern _____ **Severity (1-10)** _____

2nd Emotional Concern _____ **Severity (1-10)** _____

3rd Emotional Concern _____ **Severity (1-10)** _____

4th Emotional Concern _____ **Severity (1-10)** _____

ABOUT YOUR CHILD'S PREVIOUS HEALTH CARE

Does your child see a pediatrician? If yes, who and when was the last visit?

_____

Please list any drugs / medications / vitamins / herbs / other that your child is currently taking:

_____

Has your child ever received Chiropractic Adjustments or NetworkSpinal™ Chiropractic Entrainments by a Doctor of Chiropractic before?

◯ Yes ◯ No

If yes when and by whom? _____ **For how often and how long?** _____ **When was the last visit?** _____

And if so, what were the results with previous chiropractic care?

_____

Have you or your spouse ever received Chiropractic Adjustments or NetworkSpinal™ Chiropractic Entrainments by a Doctor of Chiropractic before?

◯ Yes ◯ No

Has your child seen any other doctors or received any other care for these concerns?

◯ Yes ◯ No

If YES, what type of care was received?

_____

What has been the result of that care?

_____

Why do you think your child's body and/or mind is not healing?

_____

CHILD'S HISTORY OF LIFE STRESS & TRAUMA

Chiropractic science is based upon the location and adjustment of Vertebral Subluxations.
Spinal Subluxations are caused by any stress that the body can not properly perceive, adapt to, or recover from.
These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL / MENTAL in nature.

MOTHER'S PREGNANCY & FERTILITY HISTORY

Please answer the following regarding before and during the pregnancy for the child:

Any fertility issues? ◯ Yes ◯ No **If yes, please explain:** _____

Did mother smoke? ◯ Yes ◯ No **If yes, how many per week** _____

Did mother drink? ◯ Yes ◯ No **If yes, how many per week** _____

Was mother ill? ◯ Yes ◯ No **If yes, please explain** _____

Was mother on medication? ◯ Yes ◯ No **If yes, please explain** _____

Was the pregnancy difficult? ◯ Yes ◯ No **If yes, please explain** _____

Please explain any notable episodes of mental or physical stress, falls/injuries of the mother during pregnancy:

_____

Please explain any other concerns or notable remarks about your child's conception or the pregnancy:

_____

_____

LABOR & DELIVERY HISTORY

Child's birth was:

☐ natural vaginal birth ☐ scheduled C-section ☐ emergency C-section ☐ other

Child's birth was:

☐ at home ☐ at a birthing center ☐ at a hospital ☐ other

At delivery Mother was:

☐ conscious ☐ semiconscious ☐ unconscious

Please check any applicable interventions or complications:

☐ prolonged labor ☐ breech ☐ drug induced
☐ pain meds ☐ epidural ☐ episiotomy
☐ vacuum extracted ☐ forceps or suction ☐ cord around the neck
☐ child icubated or isolated after birth ☐ other

Please give details and describe any other concerns or notable remarks about the mother's labor and delivery:

_____

GROWTH & DEVELOPMENT HISTORY

According to your child's pediatrician, your child is currently:

☐ developing as expected ☐ slower than expected ☐ ahead of schedule

Please check any of the following that your child has ever experienced:

☐ Colic	☐ Allergies	☐ Ear infections	☐ Frequent colds
☐ Digestive problems	☐ Torticollis	☐ Breathing problems	☐ Fatigue
☐ Irritability	☐ Constipation	☐ Diarrhea	☐ Headaches
☐ Hyperactivity	☐ Flu	☐ Bloody noses	☐ Meningitis
☐ Rashes	☐ Reflux	☐ Milk or lactose intolerance	☐ Bed wetting
☐ Asthma	☐ Sleeping disorder	☐ Other	

If you checked any of the above, please give details:

_____

Was/is your child: ☐ bottle fed formula ☐ breast fed ☐ both

Please list any difficulties? _____

Have you chosen to vaccinate your child?

☐ Yes
☐ No
☐ on scheduled
☐ on a delayed selective schedule

Has your child received the covid vaccination: ◯ Yes ◯ No

Please list any / all vaccination reactions:

_____

Has your child ever received any antibiotics?

◯ Yes ◯ No

If yes, list when, how many times and reason(s): _____

Night terrors or difficulty sleeping?

◯ Yes ◯ No

If yes, please explain _____

Behavioral, social or emotional issues?

◯ Yes ◯ No

If yes, please explain _____

Does/did child frequently arch neck/back, feel stiff, or bang head?

◯ Yes ◯ No

If yes, please explain: _____

How would you describe your child's current diet?

☐ mostly whole, organic foods
☐ high amount of processed foods
☐ pretty average
☐ still breast feading

Please list any food intolerance or allergies, and when they began:

_____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

_____

OTHER TRAUMA OR INJURY HISTORY

HOW WOULD YOU RATE YOUR CHILD'S PHYSICAL HEALTH?

- ☐ excellent
- ☐ good
- ☐ fair
- ☐ poor
- ☐ getting better
- ☐ getting worse

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

Has your child ever (check all that apply):

- ☐ been knocked unconscious
- ☐ used crutches or brace
- ☐ had falls up/down steps
- ☐ been in an auto accident
- ☐ been hospitolized
- ☐ had surgery
- ☐ suffered a broken bone
- ☐ had sprain/strain injury

Please give details of any checked above:

HOW WOULD YOU RATE YOUR CHILD'S EMOTIONAL/MENTAL HEALTH?

- ☐ excellent
- ☐ good
- ☐ fair
- ☐ poor
- ☐ getting better
- ☐ getting worse

If yes, please explain:

Is or does your child (check all that apply):

- ☐ child is nervous
- ☐ accident prone
- ☐ hyperactive
- ☐ active is sports
- ☐ learning challenged
- ☐ behavioral challenged
- ☐ have poor posture
- ☐ suffered emotional trauma

Please give details of any checked above:

HEALTH GOALS FOR YOUR CHILD

Please tell us the top three health care goals and the type of care you desire for your child.

#1 Health Goal _____ **#2 Health Goal** _____ **#3 Health Goal** _____

What type of care are you seeking in our office? (Please choose ONE that BEST describes you).

- ◯ RELIEF CARE: Symptomatic relief of pain or discomfort
- ◯ CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms
- ◯ COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

Is there anything else you wish to share which may help us to better understand your child?

☐ I hereby authorize Dr. Jackie St. Cyr, D.C., of the Innate Chiropractic Healing Arts Center, and whomever she may designate, to administer care necessary to my child named above.

Signature **Date Signed**

Printed Name **Email**

PLEASE CONTINUE BELOW TO READ AND SIGN CONSENT FOR CARE . . .

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UNDERSTANDING AND CONSENT FOR CHIROPRACTIC CARE

NetworkSpinal™ Care, aka Network Spinal Analysis (NSA), Network Chiropractic (Effective 08/15/25)

PLEASE READ AND SIGN

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides Network Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice Network Care, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care, has also been trained in traditional chiropractic care, and certified in the procedures of Network Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

Network Care does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.

Network Care consists of gentle touch contacts (called entrainment contacts) along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. Network Care adopts an approach associated with somatic (body/spinal awareness) training. There is a large body of research characterizing Network Care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts online at www.epienergetics.org/research-resources.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, reassessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

Network Spinal Care has advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, distribution of energy, and the transfer of internal information, are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to Network Care and wellness education, my practitioner(s) may perform additional assessments and offer health/spinal care or advice that is consistent with my individual needs.

It has been explained to my satisfaction, and I understand that the care offered at this office is not aform of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and helps my body develop new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension,including those that are unique to Network Care.

It is common for people receiving Network Care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness. Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our guidelines require that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease,or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation, or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

☐ I have read, or have had read to me, this Network Care Consent Form and I understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to my child receiving care, which consists of or includes wellness education for myself as the parent or guardian. I understand that consisent care is needed for lasting change and that I am an active participant in my child's health and healing.

Signature **Date Signed**

Printed Name **Email**

PLEASE CONTINUE BELOW TO READ AND SIGN FINANCIAL POLICIES . . .

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FINANCIAL POLICIES & FEES - (EFFECTIVE 08/15/2025)

We believe that finances should never be a reason to keep you from receiving quality Chiropractic Care. We are dedicated to providing you the best healthcare possible and we keep our fees “cash affordable” and family friendly.

NEW PATIENT PACKAGE (Includes all care for the first 3 visits, allowing a full experience of our care): $395

- History & Consultation, Posture & Structural Exam, 3D Body View Laser Foot Scan, CORE Score Computerized Spinal Scans
- First 2 Network Chiropractic Care Adjustments/Entrainments and 1 Massage Modality
- Doctor's Report of Findings & Recommendations (@ 2nd Visit)
- New Patient Orientation Class and Dinner With The Doc Events - for you and up to 4 adult guests

CHIROPRACTIC CARE FEES:

- Network Spinal Analysis Chiropractic Adjustment (NetworkSpinal) (97139): $80
- Somato Respiratory Integration (97139): $80
- Jeanie Rub Massage (97124): $40
- Intersegmental Traction aka “Roller Table" (97012): $40
- Chi Machine (97012): $40

EXAMINATION FEES:

- NEW PATIENT EXAM = History, Consult, Exams, CORE Score Scans, Foot Scan on initial visit and Report of Findings at return visit: $195
- 3D BodyView Laser Foot Scan Assessment: $80
- Progress Scan + Results Review (Required after the first 12 visits): $90
- Re-Evaluation + Results Review (Required after the first 24 visits and/or at other intervals in care): $110

FINANCIAL PLAN OPTIONS - PRE-PAID & AUTO-PAY CARE PLANS:

- Our pre-paid & auto-pay financial plans offer ZERO % FINANCING and a 5 - 20% DISCOUNT to save you time & money.
- FAMILY DISCOUNTS: Family is defined as those living in partnership in the same household with shared expenses. When one primary adult member (parent, spouse, significant other) is enrolled in a care plan and in regular care, additional immediate family members receive an additional 5% discount on care plans. We also have special ChiroKids fees for, children under 18, when their parents are on a regular care plan.
- Care Plan = An enrolled frequency of regular care as recommended by the doctor and that fits into your lifestyle.
- Financial Plan = How you agree to pay for care and the discounts received for one-time pay, monthly auto-debit, etc.

ACCEPCTED FORMS OF PAYMENT:

- Most services in our office are eligable for Flex & Health Savings Cards (FSA/HSA). We also accept Cash / Checks / Visa / MC / Discover / AMEX.

NON-INSURANCE & FINANCIAL RESPONSIBILITY:

- It is our policy to have you pay us directly for all services and products received at the time of service in our office.
- We do not file insurance and most insurance companies offer limited coverage for Wellness care.
- NOTE REGARDING INSURANCE: ***** Our care is Wellness based and many insurance companies, including Medicare, only cover structural/manual manipulation of the spine and do not cover our gentle care, NetworkSpinal Care, or any low-force techniques, or Wellness care.*****
- Medicare only pays for structural/manual manipulation (popping) and does not cover any other services by chiropractors.
- We do not guarantee that your policy will cover any of our services, but we will provide you with an account statement for you to submit for possible reimbursement.
- Said statement will reflect any discounts that you receive, and you should not collect reimbursement, or apply to deductible, more than your out-of-pocket expense.
- Due to government regulations, discounted offers may exclude Medicare and Medicaid members.

OTHER POLICIES & FEES:

- INSUFFICIENT FUNDS FEE - There is a $25 fee for a declined auto-debit payment or ISF check. Please notify us in advance to change or update a card on file for your plan.
- NO-SHOW FEE - There is a FULL VISIT FEE for a “NO-SHOW-NO-ADVANCE-CALL”, or it counts as a visit in your plan when you miss a visit without advanced notice.
- REIMBURSEMENT & FEES DUE AT EARLY CANCELLATION - Reimbursement for fees paid in advance for services not yet rendered (early cancellation / incomplete care plans) will be refunded, within 30 days, after pro-rating the services rendered to date. Any fees still due for services rendered will be due in full at the time of cancellation of a plan.

IMPORTANT REQUEST: THANK YOU FOR RESPECTING OUR SCHEDULED HOURS & AVAILABILITY FOR OTHERS

- **PLEASE ARRIVE 5 MINUTES EARLY TO CHECK-IN FOR ALL APPOINTMENTS so as to be on the table by the scheduled time.**
- **Please call or text ahead if you are going to be late** - don't stress, we can usually work you in.
- Please give **24-HOUR ADVANCE NOTICE** for any changes or cancellations for all appointments.
- There is a **FULL VISIT FEE for a “NO-SHOW-NO-ADVANCE-CALL**”, or it counts as a visit in a plan.

-

☐ I have read, understand, and agree to the terms of this financial policy. I may request a signed copy of this agreement at any time.

Signature **Date Signed**

_____

Printed Name **Email**

_____ _____

PLEASE CONTINUE BELOW TO READ AND SIGN PRIVACY NOTICE . . .

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HIPAA PRIVACY NOTICE - (EFFECTIVE 08/15/2025)

This office is required by federal law to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances. If at anytime you would like a more detailed explanation, you will find we have placed several copies of the comprehensive 'Notice of Privacy Practices' in the examination room.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately tothe doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from you or any other collateral source
4. For personal injury purposes - to process a claim or aid in investigation
5. Emergency - in the event of a medical emergency we may notify a family member
6. Public health & safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
7. To government agencies or law enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner, and government benefits purposes
9. Deceased persons - discussion with coroners and medical examiners in the event of a death
10. Telephone calls, emails, texts, or mailings for appointment reminders - we may call your cell, home or other number provided and leave messages, send emails, texts, postcards, or other mailings regarding a missed appointment or to inform you of changes in practice hours or upcoming events,etc.
11. New ownership - in the event this practice was ever sold the new owners would have access to your personal health information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Notice of Privacy Practices" Patient Privacy Notice
3. To request mailings to an address different than your residence
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information; however, like restrictions we are not required to agree to them
6. To obtain one copy of your records at a reasonable fee as deemed by the Texas Chiropractic Board,when timely notice is provided (15 days). X-rays prescribed by our office are considered original legal records and we must keep them in our possession for at least 7 years. You can usually obtain a complimentary personal copy from the imaging center but if there is a fee you will be responsible for that fee.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information please contact our office directly. If you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

7. I understand that the entrance to this office is a public entrance.

8. I understand that in seeking care in this office that an open/group adjusting room is part of my health & wellness care.

9. I understand that this office uses the Perfect Patient Website Service, ChiroTouch, and Review Wave systems for the purpose of running a paperless environment and that some personal information (i.e.name, date of birth, email address, cell phone, payment information, etc.) will be securely stored online thru these systems.

10. I understand that in order to maintain a high level of security, this office will keep a photo of me onfile for identification. I may refuse to have my photo taken and can substitute my Driver's License as an alternative source of identification.

11. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply if this office has already taken action in reliance on this consent.

12. I understand that if I revoke this consent at any time, this office has the right to refuse to treat me.

13. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then I will not be allowed to receive treatment in this office. I may receive a copy of this Patient Privacy Notice.

14. I understand my rights as well as the practice's duty to protect my health information and have conveyed any concerns to the staff. I further understand that this office reserves the right to amend this "Patient Privacy Policy" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

15. I am aware that a more comprehensive "Notice of Privacy Practices" is available to me and copies are available in the exam room. At this time, I do not have any questions regarding my rights or any of the information I have received.

☐ I have read, understand, and agree to the terms of this privacy policy. I may request a signed copy of this agreement at any time.

Signature **Date Signed**

_____

Printed Name **Email**

_____ _____

Thank you for completing these forms so that we can support you and your family towards better spinal health and wellness!
Now Let's Get Started!

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