**Application for Care at Premier Family Chiropractic**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Child’s Personal Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

Gender: ▢ M ▢ F

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

 **Parent A Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Parent B Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Practitioner History**

Has your child ever received chiropractic care? ▢ Yes ▢ No Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of previous chiropractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_

Were you pleased with care? ▢ Yes ▢ No Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Pediatrician/Family MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Seeking Chiropractic Care**

What is the reason for your child's visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did the problem start? ▢ Suddenly ▢ Gradually ▢ Post-Injury

Is the problem: ▢ Getting Worse ▢ Improving ▢ Constant ▢ Intermittent ▢ Unsure

What makes the problem better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the problem worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem worse during certain times of the day?

▢ No ▢ Morning ▢ Afternoon ▢ Evening ▢ Night

Is the problem interfering with:

▢ School

▢ Sleep

▢ Playing

▢ Exercise/Sports

▢ Communication

▢ Eating

▢ Attention/Focus

Has your child ever had a similar problem? ▢ Yes   ▢ No Please Explain \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has your child seen for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you pleased with care? ▢ Yes   ▢ No Please Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if your child has experienced any of the following conditions:**

▢ ADHD

▢ Asthma

▢ Allergies

▢ Auto Accident

▢ Bed Wetting

▢ Behavioral Problems

▢ Colic

▢ Constipation

▢ Dental Problems

▢ Digestive Problems

▢ Depression

▢ Ear Infection

▢ Fainting

▢ Fatigue/Low Energy

▢ Frequent Colds

▢ Growing Pains

▢ Irritability

▢ Loss of Balance

▢ Poor Coordination

▢ Poor Posture

▢ Recurring Fevers

▢ Scoliosis

▢ Seizures

▢ Sleeping Problems

▢ Sensitivity to Light

▢ Temper Tantrums

▢ Vision Changes

▢ Walking Trouble

Other health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Please list any injuries, accidents, falls and/or fractures your child has had in his/her lifetime \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In/Out-Patient/Hospitalizations/Surgical history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you chosen to vaccinate your child? ▢ Yes   ▢ No

Please describe any and all reactions to any vaccine(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply to your child and give any necessary details:

▢ Uncoordinated/Accident Prone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Has/had a chronic illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Has allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Has taken antibiotics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Currently taking medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Currently taking supplements/vitamins/herbs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy & Birth**

Our     ▢ Obstetrician ▢ Midwife ▢ Family Physician     was \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how long did labor last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours

Was labor artificially induced? ▢ Yes   ▢ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During pregnancy, did you/the mother: Experience any significant illnesses, difficulties, or trauma? ▢ Yes  ▢ No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Take any drugs/medications/supplements? ▢ Yes  ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoke or consume alcohol? ▢ Yes  ▢ No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any exposure to ultrasound? ▢ Yes  ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child in a breech position or otherwise malpositioned? ▢ Yes  ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check where/how your child was born and if any of the following were administered during labor and birth:

▢ Home Birth

▢ Birthing Center

▢ Water Birth

▢ Hospital Birth

▢ Vaginal

▢ Scheduled Caesarean

▢ Emergency Caesarean

▢ Epidural

▢ Forceps

▢ Vacuum

▢ Pitocin

▢ Artificial membrane rupture

▢ Episiotomy

▢ Cord around neck

▢ Manual traction of neck

▢ Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the birth premature? ▢ Yes  ▢ No Weeks \_\_\_\_\_\_\_\_

Was there delayed cord clamping? ▢ Yes ▢ No

Child’s Birth Weight \_\_\_\_\_\_\_ Child’s Birth Length \_\_\_\_\_\_\_

Current Weight \_\_\_\_\_\_\_ Current Height \_\_\_\_\_\_\_\_

APGAR Score \_\_\_\_\_\_ /\_\_\_\_\_\_

Please check all that apply to your child’s status immediately after birth:

▢ Jaundice

▢ Respiratory Problems

▢ Feeding Problems

▢ Displaced Joints

▢ Odd Shaped Head

▢ Broken Bones

▢ Other conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Growth & Development**

Does your child have any genetic disorder or disabilities? ▢ Yes  ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did your child:

Respond to sound \_\_\_\_\_\_\_

Follow an object \_\_\_\_\_\_\_

Hold head up \_\_\_\_\_\_\_

Vocalize \_\_\_\_\_\_\_

Site alone \_\_\_\_\_\_\_

Teethe \_\_\_\_\_\_\_

Cross crawl \_\_\_\_\_\_\_

Walk \_\_\_\_\_\_

Is/was your child breastfed? ▢ Yes   ▢ No If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If breastfed, any difficulty with breastfeeding? ▢ Yes  ▢ No ▢ N/A

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Formula introduced at age \_\_\_\_\_\_\_\_\_\_\_ What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Introduction of cow’s milk at age \_\_\_\_\_\_\_\_\_\_\_ Began solids at age \_\_\_\_\_\_\_\_\_\_\_\_

Please list any foods/juice intolerance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any difficulty with bonding? ▢ Yes   ▢ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any behavioral problems? ▢ Yes   ▢ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any night terrors, sleep walking or difficulty sleeping? ▢ Yes   ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been involved in any high impact or contact-type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ▢ Yes   ▢ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your child’s diet?

▢ Mostly whole, organic foods ▢ Average ▢ High amounts of processed foods

Does your child have regular bowel/bladder movements? ▢ Yes   ▢ No

Does your child have difficulty interacting with schoolmates or friends? ▢ Yes   ▢ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ▢ Yes   ▢ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of your child when he/she began daycare? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ▢ N/A

Average number of hours of TV/computer/iPad/technology per week? \_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if your child has ever or currently experiences any of the emotional stressors below: (check all that apply)

▢ Academic Pressures ▢ Bullying ▢ Parents’ Divorce ▢ Loss of a loved one

▢ Lifestyle Change ▢ Relocation ▢ New Sibling

**Activities of Daily Living/Symptoms/Medications**

**Daily Activities: Effects of current conditions on performance: Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:**

****

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For office use only**

I have reviewed the above ADL Form with the above named patient:

Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OUR OFFICE POLICIES**

Premier Family Chiropractic

As your child is a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you/your child can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Some of the care we provide occurs in an open bay area. This allows patients to observe the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your child’s experience with us to be an exceptional one, so help us to help your child and together we can make affirmative changes in your child’s life and the lives of those you care about.

**REPORT OF FINDINGS**

To enhance your understanding of the chiropractic approach that will be used to manage your child’s health, immediately following your child’s first adjustment, you will be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your child’s case, therefore attendance is required for individuals who wish to become new patients of this practice. We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

**NEW INJURIES**

In the event your child sustains a new injury, please let the front desk coordinator know as soon as possible. There may be additional paperwork to be filled out.

**RESCHEDULING APPOINTMENTS**

We set up specific treatment schedules for our patients. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your child’s appointment for another time. If the same day is not possible, be sure to make up the missed appointment within one week.

**PROGRESS EVALUATIONS**

Progress evaluations & re-examinations will be performed periodically to determine your child’s rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

**PATIENT ACKNOWLEDGEMENT**

I have read the above Office Policies. I acknowledge receiving a copy of the Office Policies. I further acknowledge that any concerns regarding these Office Policies as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient’s Name DOB HRN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness

\_\_\_\_\_\_\_\_\_\_\_\_

**Application for Care at**

Premier Family Chiropractic

**Informed Consent**

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Premier Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Authorized person’s Signature Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY:** please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

▢ The first day of my last menstrual cycle was on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

▢ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Authorized person’s Signature Date

**Informed Consent**

You are the decision maker for your child’s health care. Part of our role is to provide you with information to assist you in making informed choices.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your child’s condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your child’s circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate

for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)**

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record:**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record:**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications:**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share:**

If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

**Get a list of those with whom we’ve shared information:**

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for

another one within 12 months.

**Get a copy of this privacy notice:**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

**Choose someone to act for you:**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated:**

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do,

and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

**In these cases we never share your information unless you give us written permission:**

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

**In the case of fundraising:**

We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

How do we typically use or share your health information? We typically use or share your health information in the following ways:

**Treat you:**

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization:**

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

**Bill for your services:**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues:**

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone’s health or safety.

**Do research:**

We can use or share your information for health research.

**Comply with the law:**

We will share information about you if state or federal laws require it, including with the Department of Health andHuman Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests:**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director:**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests:**

We can use or share health information about you for worker’s compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions:**

We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

* We are required by law to maintain to privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
* For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm

**Changes to the Terms of this Notice:**

We can change the terms of this notice and the changes will apply to all information about you. The new notice will be available upon request.

**PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE**

**Notice to Patient:**

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your child’s health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Additional Items:

1) May we confirm your child’s appointments by email, text or phone?

▢ Yes ▢ No

2) May we leave a message on your answering device at home or cell phone?

▢ Yes ▢ No

3) May we discuss your child’s condition with any members of your family?

▢ Yes ▢ No

If yes, provide names:

**Patient Acknowledgement:**

I acknowledge and agree to this office’s HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name Patient Signature or Legal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date If legal representative, state relationship

**FOR OFFICE USE ONLY:**

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient, but it could not be obtained because:

\_\_\_ the patient refused to sign

\_\_\_ we were not able to communicate with the patient

\_\_\_ due to an emergency situation it was not possible to obtain a signature

\_\_\_ other (please provide details):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Patient Name of Staff Member

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Signature of Staff Member

**I hereby authorize payment to be made directly to this office for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to this office for any and all services I receive at this office.**

Parent or Guardian's Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

Doctor’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

**We exist to be a place where people can experience LOVE, HOPE, & RESTORATION of their God-given potential**