Child Information

Congratulations on your decision to improve your child's life!

Child's name_____ Child's Birth Date_____ Age _____ Sex M F

Parent(s) name(s)_____ Date_____

Address_____City:_____State:_____ Zip Code_____

The following is in regards to the parent:
Cell #_____ Home #_____ Email _____
(Please circle the phone number that is best to reach you at during our office hours.)
Whom may we thank for referring you to our office? _____

What kind of appointment reminder would you like? (Circle one) Text Phone Msg

Reason for consulting our office today:_____
What are your expectations for your child's care in this office?_____
Please list any concerns for your child in order of importance:

1._____ 2. _____ 3._____
Have you seen any other professional for these concerns? Y N
If yes, describe the treatment and any results: _____

Please check each of the following that has ever applied to your child:

- ☐ Sick a lot
- ☐ ADD/ ADHD
- ☐ School difficulties
- ☐ Earaches
- ☐ Poor balance or coordination
- ☐ Stress or Anxiety
- ☐ Sleeping difficulties
- ☐ Bed wetting
- ☐ Social fears/ problems
- ☐ Frequently unhappy
- ☐ Asthma/ Allergies
- ☐ Scoliosis/ Spinal problems
- ☐ X-rays or MRI
- ☐ Bone fracture
- ☐ Car accident
- ☐ Spinal or Head injury
- ☐ Falls
- ☐ Neurological conditions
- ☐ Birth Trauma (forceps, vacuum, c-section)
- ☐ Slow development
- ☐ Headaches

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your child.

_____

_____

Has your child ever been to a Chiropractor before? Y N When_____ Why did they go?_____
What were the results?_____ Why did you stop going?_____

Does your child have any conditions that may alter the way in which their care is delivered? (please describe)

_____

Please describe your child's:
Sleep (number of hours slept on the average night and the quality of sleep)_____
Diet_____
Exercise_____

Does your child take any vitamins, supplements, or medications? (Please explain)

_____

Does your child participate in any sports, lessons, talents, or hobbies? (Please explain)

_____

What is it that you want most for your child? _____

Is there anything else that we need to know about your child that was not addressed on this form?

_____

Payment Policy

Payment is due at the time of, or previous to, services being rendered. If you will not be accompanying your child on each visit to the office you may leave a credit card on file for payment. If you have insurance you may be able to be reimbursed for part of your expenses at our office (ask for an insurance receipt when you pay, it will have all the information your insurance company will need for you to submit the bill).

Missed appointments that are not cancelled or rescheduled within 24 hours of the scheduled time are subject to a $20 fee for each 10 minute time period missed.

Informed Consent

Treatment is provided in order to improve the function of the neuro-musculo-skeletal system, so the body can heal itself. However specific results can never be predicted or guaranteed. There are certain risks that have been reported to be associated with chiropractic care. Such risks include, but are not limited to fractures, dislocation, bruising, stroke, Horner's syndrome and other neurological complications. However, these incidents are extremely rare and the doctor will use his best judgment to try to avoid any negative events. The most common adverse reaction to care is temporary muscle soreness. By my signature below, I give my consent for the Doctor of Chiropractic to examine and treat my child's spine and/or extremities and/or muscle function.

Privacy Notice

Your child's health information is private and protected by law. Your child's health information will only be used or disclosed for the purposed of giving care, billing, or supporting day-to-day operations in this office. You have a right to review your child's file. You may restrict all or part of your child's health information from being released. Child records are only released when requested by a parent or guardian. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

I have read and understood the informed consent and give my permission for the Doctor of Chiropractic to deliver treatment to my child.
I have had a chance to ask questions about the privacy policy and I give my permission to this office to use my child's protected health information in accordance with the above policies.

_____
Child's Name

_____
Parent Name Parent Signature Date

_____
Witness Signature Date