STEVENS CHIROPRACTIC & WELLNESS CENTER

Child's Name _____ Gender _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Date of Birth _____ Age _____
Weight _____ Height _____ Referred by _____
Siblings (Names & Ages) _____
Race/Ethnicity (Please circle): Caucasian African American Hispanic American Indian/Alaska Native
Asian/Pacific Islander Other _____
Primary language spoken _____ Secondary language spoken _____

Mother's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

Father's Name _____ SS# _____
Address (if different) _____ City _____ State _____ Zip _____
Cell Phone Number _____ Email address _____
May we contact you by phone call, text and/or email? Please circle: Yes / No

1. FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient had any of the following illnesses & mark accordingly by noting: **M** (Mother); **F** (Father); **S** (Sibling); **PGM** (Paternal grandmother); **MGM** (Maternal grandmother); **PGF** or **MGF**.

_____ Allergy
_____ Asthma
_____ Birth Defect _____
_____ Cancer _____
_____ Diabetes / Low Blood Sugar
_____ Eczema / Psoriasis
_____ Heart Trouble
_____ High Blood Pressure / Stroke
_____ Kidney Disease
_____ Liver Disease
_____ Mental Illness / Nervous Disorders
_____ Scoliosis
_____ Seizures / Epilepsy
_____ Ulcer
_____ Other (Please explain) _____

2. PREGNANCY HISTORY

Please check any area that applied to the patient's mother during her pregnancy.

_____ Abnormal Bleeding
_____ Allergic Reactions
_____ Anemia
_____ Asthma
_____ Attitude – Happy or Depressed
_____ Back Pain or Other Pain
_____ Caffeine
_____ Chiropractic Care
_____ Complications
_____ Diabetes
_____ Excessive Increase / Decrease in Weight
_____ Heart Problems
_____ High / Low Blood Pressure
_____ Hospitalizations
_____ Indigestion
_____ Medications
_____ Mental Illness
_____ Morning Sickness
_____ Physical Injury (Fall, Car Accident)
_____ Premature Contractions
_____ Prenatal Classes
_____ Recreational Drugs / Cigarettes / Alcohol
_____ Seizures
_____ Swelling
_____ Thyroid Problems
_____ Ultrasounds
_____ Vitamins / Minerals
_____ Other (Please Explain) _____

3. LABOR & DELIVERY HISTORY

_____ Birthing Center
_____ Breastfeed at Birth
_____ Breech
_____ Cesarean
_____ Complications
_____ Doula
_____ Other (Please Explain) _____

_____ Epidural
_____ Fetal Monitor Used
_____ Forceps Used
_____ Greater than 12 hours
_____ Home Birth
_____ Hospital Birth

_____ Induced Birth
_____ Meconium Staining
_____ Medication _____
_____ Midwife
_____ Premature Delivery
_____ Vacuum Extraction

4. NATAL HISTORY

The duration of the pregnancy was _____ weeks.
The APGAR score at birth was _____.
The APGAR score at 5 Minutes was _____.
The length at birth was _____.
The weight at birth was _____.

Please check any **problems** the patient had **at birth**:

_____ Breastfeeding Problems
_____ Bottle Feeding Problems
_____ Breathing / Cyanotic (Blue)
_____ Choking
_____ Other (Please explain) _____

_____ Colic
_____ Crying
_____ Jaundice (Yellow)
_____ Sleeping Problems

Please check if any item(s) applied to the patient **at birth**:

_____ Artificial Feeding
_____ Birthmarks _____
_____ Circumcision
_____ Medication _____

_____ Vitamin K (For Clotting)
_____ Silver Nitrate
_____ Surgery _____
_____ Other (Please explain) _____

5. NUTRITION HISTORY

Please check if the patient has received any of the following items **since birth**:

_____ Breast Milk (How long? _____)
_____ Commercial Formula
_____ Cow's Milk
_____ Goat's Milk
_____ Soy Milk
_____ Other (Please explain) _____

_____ Juice: Fruit / Vegetable
_____ Medications _____
_____ Solid Foods
_____ Sweets
_____ Vitamins _____

6. DEVELOPMENTAL HISTORY

Please indicate the age in which the patient performed the following item(s):

_____ Respond to Sound Stimuli
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Upright
_____ Roll Over

_____ Crawl
_____ Stand
_____ Cruise Furniture
_____ Walk
_____ Run

7. REASON FOR THIS VISIT

Describe the purpose of this visit: _____
When did this condition begin? _____

Please indicate if this condition has/is:

_____ Worsened	_____ Constant	_____ Better in AM
_____ Improved	_____ Intermittent (Comes and Goes)	_____ Better in PM

Please indicate if this condition interferes with:

_____ Bowel Movements	_____ Eating / Drinking	_____ School
_____ Daily Routine	_____ Recreational / Play activities	_____ Sleeping

_____ Other activities _____

Has this condition occurred before? _____ Yes _____ No
Has the child seen other doctors for this condition? _____ Yes _____ No
If yes, Doctor's Name & Location: _____
Type of treatment: _____
Results: _____

8. CHILD'S HEALTH HISTORY

Please indicate each of the diseases or conditions that the child has now or has had in the past.

_____ Allergies	_____ Eczema / Psoriasis	_____ Scoliosis
_____ Asthma	_____ Fractures	_____ Seizures / Epilepsy
_____ Attention Problems	_____ Growing Pains	_____ Skin Problems
_____ Autism	_____ Hay Fever	_____ Sleeping Problems
_____ Back Pain	_____ Headaches	_____ Speech Problems
_____ Bed Wetting	_____ Hives	_____ Sports Injury
_____ Bowel Movements	_____ Hyperactivity (ADHD)	_____ Stomach Pain
_____ Breathing Problems	_____ Intestinal Gas	_____ Teeth Problems
_____ Chronic / Frequent Colds	_____ Irritability	_____ Temper Tantrums
_____ Colic	_____ Irritable Bowel Syndrome	_____ Tubes In Ears
_____ Constipation	_____ Knee Pain	_____ Urinating (Pain, Smell)
_____ Diarrhea	_____ Nail Problems	_____ Vision Problems
_____ Digestive Problems	_____ Neck Pain	_____ Vomiting
_____ Ear Problems	_____ Recurring Fevers	_____ Walking Problems

_____ Other (Please explain) _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first years of life, (i.e. off a bed, couch, changing table, down stairs, etc)
Was this the case with your child? _____ Yes _____ No

Please indicate if your child has ever had or experienced any of the following & describe details if applicable:

_____ Been Hospitalized? _____
_____ Been in a Car Accident? _____
_____ Had a Serious Fall? (Bicycle, Skateboard, Rollerblades, etc) _____
_____ Had any Broken bones? _____
_____ Had any Surgeries? _____
_____ Has or had any major illnesses? _____

9. VACCINATIONS & MEDICATIONS

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

Please indicate which of the following vaccines your child has received:

_____ DTaP (Diptheria, Tetanus, Pertusis)
_____ Gardisil (For Females)
_____ Hepatitis B
_____ Hib (Haemophilus Influenza type B)
_____ MMR (Measles, Mumps, Rubella)
_____ Pneumococcal conjugate (PCV)
_____ Polio
_____ Varicella (Chicken Pox)
_____ Other (Please explain) _____

Please describe any and all reactions to the vaccines: _____
_____

Please indicate if you have you had any foreign travel (where & when): _____

Please indicate any medications and the dates that your child has or is taking:

_____ Antibiotics _____ Aspirin _____ Ibuprofen
_____ Anti-Gas Medicine _____ Cold Medicine _____ Tylenol
_____ Other Over-The-Counter Medicine _____
_____ Other Prescribed Medicine _____

Has your child had any reactions to any medications? _____ Yes _____ No
If yes, please explain: _____

Name & Location of Pediatrician: _____
Date of last visit: _____ Reason: _____

10. AUTHORIZATIONS & CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my child as the examining and treating doctor deems necessary. If any x-rays are taken they will remain the property of this office. The payment to the office for the x-rays is for the x-ray films and the examination of the x-rays. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care. Any returned checks are subject to a $30 service charge. I hereby authorize assignment of my insurance rights and benefits (if applicable to the provider for services rendered).

_____ _____
Child's Name Relationship to child

_____ _____
Parent/Guardian's Name Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Patient Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

APPOINTMENTS

To ensure that our patients receive the highest quality of care, we limit the number of patients we see each day. Each individual is given the time and attention needed to discuss his/her progress, answer questions, and provided with treatment and instructions. After your initial visit, which usually takes one hour, return visits are scheduled with the doctor for fifteen minutes. We have found this mode of treatment maximizes the benefit of each visit and usually results in less frequent office visits. We realize that your time is valuable and we do our best to stay on schedule. Therefore, we ask that you notify our office at least 24 hours in advance if you are not able to keep an appointment. Your co-operation will help us utilize an appointment for someone else needing care.

FINANCIAL POLICY

We cannot bill your insurance company unless you give us your insurance information. In the event that your insurance carries a deductible, payment will be required at the time of service until your deductible is met. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. In the event that your insurance coverage changes, along with benefits, please be aware that your financial obligations may change with our office. Please understand that you are ultimately responsible for payment of any services rendered within our office. If payment is not received on past due account balances, accounts will be turned over for collection, which will include the full service fee charges, collection service charges, and daily interest. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the information above regarding appointments and financial policy and I fully understand and agree.

_____

Patient Name (PLEASE PRINT)

_____ _____

Patients Signature Date

Revised January 2018

Informed Consent for Chiropractic Treatment

TO THE PATIENT: ***You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.***

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the licensed Doctors of Chiropractic working at Stevens Family Chiropractic. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

~ Broken bones / Sprains/strains
~ Dislocations
~ Burns or frostbite (physical therapy)
~ Worsening/aggravation of spinal conditions
~ Increased symptoms and pain
~ No improvement of symptoms or pain
~ Infection (acupuncture)
~ Punctured lung (acupuncture)

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____ _____
witness to patient's signature date

_____ _____
translated by date

Revised January 2018

CONSENT FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE Stevens Family Chiropractic and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

Patient name: _____

Parent/Guardian signature: _____

Witness Signature: _____

Remarks: _____

_____

_____

_____

_____

_____

_____

Doctor's Signature: _____

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