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CHIROPRACTIC & WELLNESS

Patient Information

Contact Information

Name _____ Preferred Name _____

Email address _____ Pronouns _____

Primary Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Additional Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Address _____

City _____ State _____ Zip Code _____

Sex ☐ Male ☐ Female Gender _____ Birth Date _____ / _____ / _____ Age _____

If a minor, Parent/Guardian Name(s) _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow Number of Children _____

Occupation _____ Employer/School_____

Work/Student Status ☐ Full time ☐ Part time

Preferred Appointment Reminder Notification Method(s) ☐ Email ☐ Text ☐ Both

How did you hear about us? _____

Insurance Information

Insurance Company _____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Name _____ Birth Date _____ / _____ / _____

Policy Holder Address (if different from above) _____

City _____ State _____ Zip Code _____

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Pediatric Health History

Patient Name _____ **Today's Date** _____

Current Health History

What's bringing you in today? _____

What do you think caused this problem? _____

How long has your child had this problem?_____

How often does your child experience the issue?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

How is the issue changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

What makes it worse? _____

What makes it better? _____

Who else has your child seen for this problem?

☐ Chiropractor ☐ Lactation Consultant ☐ Pediatric Dentist
☐ Primary Care Physician ☐ Craniosacral Therapist ☐ Other:
_____
☐ Occupational Therapist ☐ Physical Therapist ☐ No one

Any other details to share? _____

Medical Health History

For each of the conditions listen below, place a check in the "past" column if your child had the condition in the past. If your child presently has a condition listed, place a check in the "present."

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	W-sitting	☐	☐	Ear infection(s)
☐	☐	Neck Pain	☐	☐	Toe walking	☐	☐	Respiratory infection(s)
☐	☐	Back pain	☐	☐	Low muscle tone	☐	☐	Asthma
☐	☐	Arm pain	☐	☐	Abnormally clumsy	☐	☐	Allergies
☐	☐	Leg pain	☐	☐	Milestones regression	☐	☐	Skin rash(s)
☐	☐	Growing pains	☐	☐	Excessive crying	☐	☐	Sleep problems
☐	☐	Preferred head position	☐	☐	Frequently spits up	☐	☐	Bed wetting
☐	☐	Arches head/neck back	☐	☐	Excessive gassiness	☐	☐	Tongue and/or lip tie
☐	☐	Has a "strong neck"	☐	☐	Digestive problems	☐	☐	Behavioral issues
☐	☐	Torticollis/head tilt	☐	☐	Constipation	☐	☐	Seizures
☐	☐	Flat spot on head	☐	☐	Breastfeeding difficulties	☐	☐	Other: _____
☐	☐	Uneven crawling/gait	☐	☐	Frequent hiccups			_____

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List all prescription medications your child is currently taking:

_____

List all over-the-counter medications/supplements your child is currently taking:

_____

List all surgical procedures your child has had:

_____

Have your child had significant past trauma? ☐ No ☐ Yes, _____

Pregnancy and Birth History

☐ Pregnancy history unknown, _____

Where was your child born? _____

How were they born? ☐ Vaginally ☐ C-section

Describe your child's birth story: _____

Is there anything else pertinent to your visit today? _____

Name of person completing this form _____

Relationship to patient _____

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Receipt of Notice for Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices for Evergreen Chiropractic (formally known as “Jackson Chiropractic Clinic”) regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the Clinic and my respective rights therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (651) 483-4321.

My signature below herein constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Jackson Chiropractic Clinic.

Payment Agreement

I authorize the release of any medical information necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor’s office.

I am personally responsible for supplying accurate and current information.

I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this statement to serve as an original.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

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Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Nature of Chiropractic Care. The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible noise, and you may feel a sense of movement.

Analysis, Examination, Treatment. As part of the analysis, examination, and treatment, you are consenting to the following procedures, but not limited to:

Spinal manipulative therapy	Range of motion testing	Therapeutic ultrasound
Palpation	Orthopedic testing	Hot/cold therapy
Vital signs	Basic neurological testing	Electric muscle stimulation
	Radiographic studies	

Risk Inherent with Chiropractic Care. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The Doctor will make every reasonable effort during the examination to screen for contraindications of care. These complications include, but are not limited to: muscle strain, burns, fractures, disc injuries, dislocations, cervical myelopathy, and costovertebral stains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

Other Available Treatment Options. Other treatment options for your condition may include self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physicians.

Risk of Remaining Untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my care provider(s) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

Doctor Name: _____

Doctor Signature: _____ Date: _____