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CHIROPRACTIC & WELLNESS

Chiropractic - Pediatrics

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) _____

Parent/Guardian Phone _____ Email _____

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? _____

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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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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: _____

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Authorization for Care of a Minor

Patient's Name _____ Date of Birth _____

Parent/Guardian Name(s) _____

Relationship _____

I, hereby, authorize Evergreen Chiropractic to render any chiropractic services necessary for the treatment of the patient listed above. These services include but are not limited to: physical examination, chiropractic adjustments, therapeutic procedures, traction, electric muscle stimulation, and manual muscle work, within the scope of chiropractic practice.

I, hereby, give consent for the patient listed above to be treated even if I or another parent is unable to attend the appointment. As a parent/guardian, I am financially responsible for any services rendered during the visit. Any question or concerns can be directed toward the treating doctor at any time.

Parent/Guardian Signature _____ Date _____

For doctor to complete:

As a Doctor of Chiropractic, we will perform services to the best of your ability, upholding the integrity of our practice. We will treat the patient with respect and only perform services we deem necessary for the treatment of the condition.

Doctor Name _____

Doctor Signature _____ Date _____

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Payment Information & Agreement
Chiropractic

Patient Name _____ Date _____

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 _____

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

Patient Initials

Financial Responsibility Acknowledgment

I understand that **co-pays are due at the time of service.**

If I have **not yet met my deductible** and no co-pay is required, I agree to pay a **$45 down payment** toward my account at the time of service. This payment will be applied to any charges determined by my insurance provider once claims are processed. I acknowledge that the final amount I owe may be **more than $45**, in which case I will be billed for the remaining balance.

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 Initials

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Patient Name _____ Date _____

Credit Card on File Authorization

Card Number _____

Expiration Date _____ Security Code _____ Zip Code _____

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

☐ **Please charge my card for any and all charges, including balances remaining after insurance payments are processed.**
I authorize automatic charges to my card on file for co-pays, co-insurance, deductibles, and any remaining balances as they are billed.

☐ **Please charge my card only after I have reviewed and approved each charge.**
You will contact me for confirmation before charging my card on file. I understand I am still expected to pay upon receipt of my statement.

☐ **Do not charge my card on file.**
I understand I am responsible for all balance and will pay by another method upon receiving a statement.

Signature _____ Date _____

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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 Evergreen Chiropractic.

Patient Name: _____

Patient Signature: _____ Date: _____

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