Forever Young Chiropractic

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

PEDIATRIC

Date: ______________________

PATIENT INFORMATION

Name: ____
(LAST) (MI) (FIRST)

Address: ____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ____________________ Cell Phone: ____________________

Email Address: ____________________ Sex: Male: ____ Female: ____

DOB: ____________________ Social Security #: ____________________

Mother's Name: ____________________ Father's Name: ____________________

Emergency Contact: ____________________ Phone Number: ____________________

Relationship to Patient: ____________________

Reason for contacting our office: ____________________

Who can we thank for the referral: ____________________

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto

Insurance Name: ____________________

Member #: ____________________ Group #: ____________________

Insurer's Name: ____________________ Insurer's DOB: ____________________ Insurer's Soc. Sec. #: ____________________

Insurer's Employer: ____________________ Person responsible for account: ____________________

Assignment of Benefits

I hereby give my consent to Forever Young Chiropractic to provide services to me and/or my family. I understand that I am financially responsible for all charges whether or not paid by insurance and that fees are payable at the time services are rendered. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for obtaining payment for services and determining insurance benefits payable for related services. **I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary**.

Parent/Guardian Signature: ____________________ Date: ____________________

Forever Young Chiropractic

CONFIDENTIAL DETAILED HISTORY FORM – PLEASE PRINT

PEDIATRIC

HEALTH HISTORY

If your child has no symptoms or complaints, and is here for wellness services, please check here: ☐

Describe the reason for the visit:____
____

How long has your child experienced this problem? ____

What was this problem the result of? ____

Has it gotten better or worse over time? Better: ___________Worse: ______________
About the same: _____________Comes and goes:_____________

Has your child seen any other doctors for this problem? Yes:____No:___
If "yes", please list all other doctors:____

Has your child previously received chiropractic care? Yes:____No:____
If "yes", date of last care and reason: ____

Are you content with the overall health of your child? Yes:____No:____

Please circle if your child has experienced any of the following and how often:

O=OCCASIONAL **F=FREQUENT** **C=CONSTANT**

O	F	C		O	F	C		O	F	C	
Y	Y	Y	Ear Infections	Y	Y	Y	Headache	Y	Y	Y	Allergies
Y	Y	Y	Hearing Impairment	Y	Y	Y	Digestive Problems	Y	Y	Y	Chronic Colds
Y	Y	Y	Vision Impairment	Y	Y	Y	Constipation	Y	Y	Y	Sinus Troubles
Y	Y	Y	Sleeping Problems	Y	Y	Y	Diarrhea	Y	Y	Y	Bronchitis/ UR Infections
Y	Y	Y	Colic	Y	Y	Y	Weight Loss	Y	Y	Y	Fatigue
Y	Y	Y	Hyperactivity	Y	Y	Y	Back Pains	Y	Y	Y	Bed Wetting
Y	Y	Y	Attention Problems	Y	Y	Y	Neck Pains	Y	Y	Y	Growing Pains
Y	Y	Y	Recurring Fevers	Y	Y	Y	Scoliosis	Y	Y	Y	Eczema/Skin Problems
Y	Y	Y	Seizures	Y	Y	Y	Asthma	Y	Y	Y	Boils

List any other health concern(s) or issues the child may be dealing with that is different from the above complaint:____
____

Birth and Delivery:

Height (current): ___________________ Weight (current):____________________
Birth weight (if applicable): ____________________Birth height (if applicable):__________________

Duration of Gestation:______________________________weeks

Where was the baby born? Hospital_____________Home:________Birthing Center:Other:________

Who was present? OB/GYN:______________Midwife:_____________Doula:_______________

Was the birth assisted? Yes:___No:____
If "yes", how? Forceps:______Vacuum Extraction:_____C-Section:_____Induced Labor:_________

Was your water broken? Yes:___No:____

How long was the labor?_____________________ How long did you push?_____________________

Did you have an epidural? Yes:___No:____

Was Pitocin/Oxytocin administered? Yes:___No:____

Were there any complications to the pregnancy?____

Was the baby ever in the Breech position? Yes: _____No: ______

Any evidence of trauma during birth? Odd-shaped head:_____Bruises: ______ Stuck in birth canal: ______
Fast and/or excessively long birth: _____ Respiratory Depression:______ Cord around neck: ______
Other: ____

Was this a single birth or multiple birth?_____________________

Has your child been vaccinated? Yes:____No:____
If "yes", was it delayed schedule or regular schedule (including Vit K):________________________

Any reaction to the vaccination? Yes:____No:____
If "yes", please describe the reaction:____

Is/Was your child breastfed? Yes:____No:____
If "yes", please list for how long:___________________________________

How often does your child have a bowel movement?____

Pre-natal/ Mother's Health History

During pregnancy, did the child's mother:

Take any medication? Yes:___No:____
Smoke? Yes:___No:____
Consume alcohol? Yes:___No:____
Take any supplements or vitamins? Yes:___No:____
Have any falls or accidents? Yes:___No:____
Receive any ultrasounds? Yes:___No:____
Receive any invasive procedures (i.e. Amniocentesis, CVS etc.) Yes:___No:____

Growth and Development

Was the infant alert and responsive within 12 hours of the delivery? Yes:___No:____
If "no", explain:____

Does your child's sleeping pattern seem normal? Yes:___No:____

Did/does your child have issues breastfeeding? Yes:___No:____

Does your child have any difficulties sleeping (e.g. night terrors, sleep walking, bed wetting etc.)? ______
____

Does your child have any behavioral issues? Yes:___No:____
If "yes", please explain: ____

Did the child have any childhood illnesses? Yes:___No:____
If "yes", please explain: ____

Has your child ever had any antibiotics? Yes:___No:____
If "yes", how many rounds and for what reason?__________________________________
____

Has your child ever had prolonged use of medications or an inhaler? Yes:___No:____
If "yes", please list below:
Name______________________________Function/Purpose_______________________________
Name______________________________Function/Purpose_______________________________
Name______________________________Function/Purpose_______________________________
Name______________________________Function/Purpose_______________________________

Does your child take any Vitamins and/or Supplements? Yes:___No:____
If "yes", please list:____
____

Has your child ever had any X-Rays or other images done? Yes:___No:____
If "yes", please describe the reason:____
____
____

Has your child had any major falls or accidents since birth? Yes:___No:____

If “yes”, please describe what happened and if anything was broken or stitches were required:

____

Has your child ever been hospitalized? Yes:___No:____

If “yes”, please explain: ____

____

Has your child ever had any surgeries? Yes:___No:____

If “yes”, please explain: ____

____

Does your child play any sports or instruments? Yes:___No:____

If “yes”, please list all sports and instruments and how many times per week: ______________

____

____

Family History:

PLEASE INDICATE BY CHECKING IN THE APROPRIATE SPACE ANY SYMPTOMS IN YOUR FAMILY HISTORY

THIS IS A CONFIDENTIAL HEALTH REPORT

__Alcoholism
__Anemia
__Antihypertensive Meds.
__Appendicitis
__Arteriosclerosis
__Arthritis
__Cancer
__Cardiovascular Dz.
__Chorea
__Cold sores
__Diabetes
__Diphtheria
__Eczema
__Emphysema
__Epilepsy
__Fever blisters
__Goiter
__Gout
__Heart disease
__Hypertension
__Influenza
__Lumbago
__Malaria
__Measles
__Miscarriage
__MTHFR
__Multiple Sclerosis
__Mumps
__Oral Contraceptives
__Ovarian Cysts
__Pleurisy
__Pneumonia
__Polio
__Rheumatic fever
__Scarlet fever
__Stroke
__TIAs
__Tuberculosis
__Typhoid Fever
__Ulcers
__Venereal Dz.
__Whooping Cough

__Other:____

Please list any other conditions or issues you wish to let us know:___________________________

____

____

____

Parent/Guardian Signature______________________________________ Date__________________

Forever Young Chiropractic

OFFICE POLICY

So that you will be aware of our office policy, please read the following information carefully. By executing this agreement, you are agreeing to pay for all services that are rendered. If at any time you have questions, please feel free to discuss the matter with any member of the staff.

MONTHLY STATEMENT

If you have a balance on your account, we will send you a monthly statement. Please make sure to pay any balances before they are over 30 days, after which they will be considered past due and a $3.00 service charge will be added.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE

1. Payment is due at time of service unless other arrangements are made.
2. Payment options are available such as cash, check or credit card.
3. For all products, payment is due at time of purchase.

PAYMENT OPTIONS IF YOU HAVE INSURANCE

1. Payment is due at time of service for your deductible and/or co-pay unless other arrangements are made.
2. Payment options are available such as cash, check or credit card.
3. For all products, payment is due at time of purchase.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your coverage. You agree to pay any portion of the charges not covered by insurance, including deductible, co-payments and any service rejected by your insurance company. If your insurance company continuously denies payment on a claim, it will become your responsibility to contact them.

INITIALS ________

RETURNED CHECKS

There is currently a $20.00 fee for any checks returned by the bank for insufficient funds.

CHIROPRACTIC APPOINTMENTS

- Most of our patients are seen by appointment only, except in emergency situations.
- While we try to accommodate walk-ins, we prefer our patients to schedule appointments to minimize waiting. Scheduled appointments are taken ahead of walk-ins.
- If you are unable to keep a scheduled appointment, we ask that you please give 24 hours' notice.
- Should an emergency arise, please call to let us know that you will not be keeping your appointment.
- For those who consistently miss appointments without notice, there will be a $20.00 missed appointment fee.

Patient/ Guardian Signature:____

Today's Date:_____________________________

FOREVER YOUNG CHIROPRACTIC

DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC
* INFORMED CONSENT FORM *

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses, and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor provides a specialized, non-duplicating health service. The chiropractor is licensed in a special practice and is available to work with other types of providers in your health care regime.

At Forever Young Chiropractic, we use a combination of different treatment procedures. We will use our hands, our adjusting table, and/or our activator device to deliver safe and gently adjustments. This may cause an audible "pop" or "click," much as you experience when you crack your knuckles. You may or may not experience or feel a sense of movement in the joint being adjusted.

Conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control, or be helped through, medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both make great strides in alleviating pain and controlling disease.

With any health care procedure there are certain complications that may arise, and we strive to inform you of such risks. High force, extreme rotation adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Massage and trigger point therapies have an associated risk of bruising and/or release of emboli. Heat therapies may cause first and second-degree burns and/or hemorrhage. Risks associated with over-the-counter medications and prescription drugs are undesirable side effects such as liver damage and patient dependence. The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, and an extended convalescent period. The risks associated with remaining untreated are the formation of adhesions and reduction of mobility depending on the severity.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor 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 myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Forever Young Chiropractic to perform the treatment and acknowledge that no guarantee as to the results that may be obtained from this treatment has been given to me.

Patient Name (please print):_____________________________

Parent/Guardian (please print):_____________________________

Patient/ Guardian Signature:_____________________________

Date: ___________________________

FOREVER YOUNG CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Forever Young Chiropractic (FYC) has the right to change its Notice of Privacy practices from time to time and that I may contact FYC at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print):____

Parent/Guardian (please print):____

Patient/ Guardian Signature:____

Date: ______________________________

I give consent for my provider to discuss my medical care with the persons listed below:

Name: ____ Relationship: ____________________________

Signature: ____

(Authorized Representative must show ID)

Name: ____ Relationship: ____________________________

Signature: ____

(Authorized Representative must show ID)

Name: ____ Relationship: ____________________________

Signature: ______________________________________

(Authorized Representative must show ID)