

# 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: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Other: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Parent #1 Name: \_\_\_\_\_ Parent #2 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 Pl/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**

Y Y Y Ear Infections  
Y Y Y Hearing Impairment  
Y Y Y Vision Impairment  
Y Y Y Sleeping Problems  
Y Y Y Colic  
Y Y Y Hyperactivity  
Y Y Y Attention Problems  
Y Y Y Recurring Fevers  
Y Y Y Seizures

**O F C**

Y Y Y Headache  
Y Y Y Digestive Problems  
Y Y Y Constipation  
Y Y Y Diarrhea  
Y Y Y Weight Loss  
Y Y Y Back Pains  
Y Y Y Neck Pains  
Y Y Y Scoliosis  
Y Y Y Asthma

**O F C**

Y Y Y Allergies  
Y Y Y Chronic Colds  
Y Y Y Sinus Troubles  
Y Y Y Bronchitis/ UR Infections  
Y Y Y Fatigue  
Y Y Y Bed Wetting  
Y Y Y Growing Pains  
Y Y Y Eczema/Skin Problems  
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:

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Has your child ever been hospitalized? Yes:\_\_\_No:\_\_\_  
If "yes", please explain: \_\_\_\_\_

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Has your child ever had any surgeries? Yes:\_\_\_No:\_\_\_  
If "yes", please explain: \_\_\_\_\_

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Does your child play any sports or instruments? Yes:\_\_\_No:\_\_\_  
If "yes", please list all sports and instruments and how many times per week: \_\_\_\_\_

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**Family History:**

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

**THIS IS A CONFIDENTIAL HEALTH REPORT**

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- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Fever blisters      | <input type="checkbox"/> Pleurisy        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Antihypertensive Meds. | <input type="checkbox"/> Gout                | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Appendicitis           | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arteriosclerosis       | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Scarlet fever   |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Influenza           | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Lumbago             | <input type="checkbox"/> TIAs            |
| <input type="checkbox"/> Cardiovascular Dz.     | <input type="checkbox"/> Malaria             | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Chorea                 | <input type="checkbox"/> Measles             | <input type="checkbox"/> Typhoid Fever   |
| <input type="checkbox"/> Cold sores             | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> MTHFR               | <input type="checkbox"/> Venereal Dz.    |
| <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Whooping Cough  |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Mumps               |  |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Oral Contraceptives |  |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Ovarian Cysts       |  |

Other: \_\_\_\_\_

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

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Forever Young Chiropractic

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## 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.

### **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)