CHILD NEW PATIENT FORM

# Spine by Design Chiropractic

*-Better health by design-*

Name_____ Date_____/_____/_____ Age_____ Male/Female

Address_____ City_____ State____ Zip_____

Birthday _____/_____/_____

Mother's Name _____ Father's Name _____

Phone: Mother's Phone_____ Father's Phone _____ Home_____

Parent(s) email_____

Who may we thank for referring you/how did you hear about us? _____

## PLEASE LIST CURRENT HEALTH CONCERNS BELOW

| Health Concerns: List according to severity | When did this begin? | Have you had this issue before? When? | Rate of Severity 1= mild 10 = unbearable | Did the problem begin with an injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| 1._____ | _____ | _____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ | _____ | _____ |

If it's pain you're experiencing, what kind: Dull Sharp Ache Numb/Tingly Other: _____

Is the pain (circle): Worse in the morning Worse in the evening Other: _____

Since your condition began, has it _____ GOTTEN BETTER _____ GOTTEN WORSE _____ ABOUT THE SAME

What makes it better? _____What makes it worse? _____

Does your condition affect (circle all that apply): Sleeping Playing Walking Sitting Standing Daily Routine

Pain radiates to _____ What doctor(s) have you seen for this? _____

If you were feeling 100% healthy, what could you do that you cannot currently do? _____

_____

- I authorize the doctors and staff of Spine by Design Chiropractic to render care as deemed appropriate for me.
- I authorize Spine by Design Chiropractic to release and request records to or from other providers as may be necessary.
- I authorize Spine by Design Chiropractic to release all necessary information to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me.
- I understand I am responsible for all bills incurred in this office.
- I understand Spine by Design Chiropractic follows HIPAA compliance guidelines.

Patient Signature _____ Date _____

(This represents a long-term authorization for all occasions of service.)

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## HEALTH HISTORY (Circle all that apply)

| | | |
|---|---|---|
| ADD/ADHD | DIARRHEA | REFLUX |
| ALLERGIES | DIGESTIVE ISSUES | RECURRING SINUS PROBLEMS |
| BED WETTING | DIZZINESS | SCOLIOSIS |
| BROKEN BONES | EAR INFECTIONS | SEIZURES |
| CHICKEN POX | FEVER | SLEEPING PROBLEMS |
| CHRONIC COLDS | GROWING PAINS | STITCHES |
| COLIC | HEADACHES | TEMPER TANTRUMS |
| CONSTIPATION | MEASLES | OTHER: _____ |
| DENTAL PROBLEMS | MEDICATION SIDE EFFECTS | |
| DIABETES | MUMPS | |

## PREGNANCY

Ultrasound(s) during pregnancy: ☐No ☐Yes If yes, how many? _____

Medication(s) during pregnancy /delivery: ☐No ☐Yes If yes, list: _____

Drug/Cigarette/Alcohol use during pregnancy: ☐No ☐Yes

Location of birth: ☐Hospital ☐Birthing Center ☐Home

Complications during pregnancy/delivery: ☐No ☐Yes If yes, explain: _____

_____

Was the child breast fed? ☐No ☐Yes If yes, how long? _____

Number of courses of antibiotics child has taken in the last year: _____

Current medication(s): _____

Name of Pediatrician or other Doctors: _____

Date of last visit: _____/_____/_____ Reason: _____

## FAMILY HEALTH HISTORY

Father's side: ☐Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history we should know about? _____

## -FOR OFFICE USE ONLY-

_____

_____

_____

_____ _____

STAFF OF SPINE BY DESIGN CHIROPRACTIC DATE

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# INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARILY TO CHIROPRACTIC CARE INCLUDES: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIRORPACTIC CARE, AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER FIVE MILLION IS CERVICAL SPINE (NECK) ADJUSTMENTS THAT MAY CAUSE A VERTEBRAL ARTERY INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

**I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.**

_____

**PATIENT'S NAME**

_____

**PATIENT'S PARENT/GUARDIAN NAME**

_____ _____

**PATIENT'S PARENT/GUARDIAN SIGNATURE** **DATE**