



PEDIATRIC PATIENT REGISTRATION

Patient Name: _____ Date: _____
Age: _____ Birth date: _____ Parent Name (s): _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Email Address: _____
Birth interventions (pitocin, antibiotics, forceps, vacuum, cesarean, etc): _____

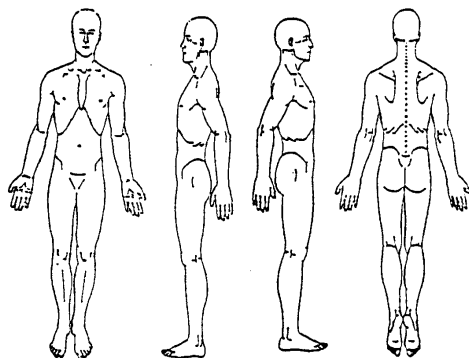
Whom may we thank for referring you? _____
Been treated by a Chiropractor before? _____ Date of Last visit: _____
Please list practitioner names and specialties of other health care providers: _____

Do I have your permission to contact them to coordinate care? Yes No
List any medications/vitamins/supplements (prescribed, or over-the counter) with the reason taken, dosage, and duration: _____

Any diagnosed health conditions? _____
Emergency Contact: _____ Number: _____ Relationship: _____

MAIN COMPLAINT

If you are here for wellness, please check here and continue to "Past Health History"
Reason(s) for consulting this office: _____
Date problem began: _____
Does it seem to be getting: Worse Better Staying the same
It interferes with: Sitting Playing Sleep Walking Hobbies Leisure Other
Mark current problem areas on these pictures (if applicable):



Please circle the current level of discomfort your problem causes you, when it is at its worst:
none 1 2 3 4 5 6 7 8 9 10 worst ever

LIFESTYLE

	<u>YES</u>	<u>Notes, if YES</u>
Does child consume caffeine?_____	<input type="checkbox"/>	
Does child consume much sugar?_____	<input type="checkbox"/>	
Does child eat a lot of vegetables?_____	<input type="checkbox"/>	
Does child eat fast/processed foods?_____	<input type="checkbox"/>	
Does child exercise?_____	<input type="checkbox"/>	
Does child drink a lot of water?_____	<input type="checkbox"/>	
Does child seem to hold much stress?_____	<input type="checkbox"/>	
Does child watch TV, play video/computer games__	<input type="checkbox"/>	

Please rate how willing you are to make lifestyle changes with your child to help accomplish your goals

Unwilling to change at all 1 2 3 4 5 6 7 8 9 10 completely willing

FAMILY HEALTH HISTORY

Cancer High Blood Pressure Heart Problems Stroke Diabetes Other _____

HEALTH HISTORY

Please check all symptoms your child has ever had, even if they do not seem related to current problem

<u>YES</u>	<u>Notes</u>	<u>YES</u>	<u>Notes</u>
Surgery/Hospitalization_____	<input type="checkbox"/>	Kidney infections_____	<input type="checkbox"/>
Serious injuries or traumas__	<input type="checkbox"/>	Bladder infections_____	<input type="checkbox"/>
Allergies_____	<input type="checkbox"/>	Cancer/tumor _____	<input type="checkbox"/>
Headache_____	<input type="checkbox"/>	Digestive complaints_____	<input type="checkbox"/>
Change in bowel habits_____	<input type="checkbox"/>	Constipation_____	<input type="checkbox"/>
Abnormal weight gain/loss__	<input type="checkbox"/>	Poor sleep_____	<input type="checkbox"/>
Abnormal fatigue_____	<input type="checkbox"/>	Colic_____	<input type="checkbox"/>
Heartburn/indigestion_____	<input type="checkbox"/>	Neck pain_____	<input type="checkbox"/>
Cold/flu often_____	<input type="checkbox"/>	Jaw pain_____	<input type="checkbox"/>
Sinus infection_____	<input type="checkbox"/>	Arm/elbow/wrist pain_____	<input type="checkbox"/>
Asthma_____	<input type="checkbox"/>	Shoulder pain_____	<input type="checkbox"/>
Chronic cough_____	<input type="checkbox"/>	Mid back pain_____	<input type="checkbox"/>
Breathing difficulty_____	<input type="checkbox"/>	Low back pain_____	<input type="checkbox"/>
Dizziness/fainting_____	<input type="checkbox"/>	Scoliosis_____	<input type="checkbox"/>
Ear infection _____	<input type="checkbox"/>	Hip pain_____	<input type="checkbox"/>
Serious illness _____	<input type="checkbox"/>	Leg pain_____	<input type="checkbox"/>
Visual disturbances_____	<input type="checkbox"/>	Knee pain_____	<input type="checkbox"/>
Nausea_____	<input type="checkbox"/>	Ankle pain_____	<input type="checkbox"/>
Balance difficulty_____	<input type="checkbox"/>	Foot pain_____	<input type="checkbox"/>
Rash or hives_____	<input type="checkbox"/>	Misshaped head_____	<input type="checkbox"/>
Slow healing_____	<input type="checkbox"/>	Bed wetting_____	<input type="checkbox"/>
Asocial with others_____	<input type="checkbox"/>	Highly emotional_____	<input type="checkbox"/>
Birth trauma _____	<input type="checkbox"/>	Vaccinated?_____	<input type="checkbox"/>



Insurance Information (if applicable)

Patient Name: _____ Date of Birth: _____
 ID #: _____ Group or Plan #: _____
 Insurance Company: _____
 Insurance Address: _____
 Customer Service Phone #: _____ Insurance Fax: _____
 Primary Subscriber (if not Patient): _____ Employer: _____
 SSN of Insured: _____ DOB of Insured: _____
 Insured Relationship to Patient: _____ Insured is: Male Female

Please call your insurance company to obtain the following information

1. Beginning date of coverage: _____ Ending date of coverage: _____
2. Does your plan have Chiropractic benefits? Yes No
3. If yes:

	In- Network Benefits	Out-of Network Benefits
Deductible		
Amount met so far		
Co-pay/ Co-insurance amount		
% Covered		
Maximum coverage \$ amount		
\$ met so far		
Maximum # visits per year		
# met so far		

4. Is there any coverage for Massage Therapy Acupuncture Naturopathy Physical Therapy

Notes: _____

5. Annual date of renewal: _____
6. Name of representative spoken with: _____ Date: _____



Consent Form, Business Agreement, Insurance Information

1. Consent to Treatment

The nature of Chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her hands or tools to adjust your joints and align your soft tissues. You may hear a “click or pop”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, Craniosacral therapy, traction, taping and exercise/nutritional instruction may also be employed.

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular strain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

2. Privacy Policy

I understand that Dr. Desbrow may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it.

3. Cancellation and No Show Policy

I understand that without giving Dr. Desbrow 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.

4. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my medical records relating to claim for benefits submitted.

5. Authorization to Communicate via E-mail

Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information.

By initialing here _____, I consent Dr. Desbrow to communicate via e-mail in spite of the above.

Signature of Patient or Guardian _____ Date _____

Patient Name (please print) _____