TEAM
CHIROPRACTIC
& Sports Medicine, P.A.

PEDIATRIC CONSULTATION

(10 years old or older)

Patient information

Child's Name _____ Sex: Male / Female
Child's Birthday: _____
Parent or Legal Guardian Name _____
Address: _____
City, State, Zip: _____ Home Phone:_____
Where do prefer to receive calls? _____ Work Phone: _____
Person to contact in case of emergency? _____ Phone: _____
Pediatrician? _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to patient: _____

What was your child's birth like? _____

How long was the entire labor? _____ How long did you actually push? _____

Were you induced? Yes No Epidural? Yes No C-Section? Yes No

Was there any pulling on the head? Yes No Any vacuum extraction? Yes No

Has your child been immunized? Yes No Any reactions? Yes No

Explain any reactions: _____

When was the child's most recent fall? _____

Was any care given? _____ Was s/he checked by a chiropractor? _____

And the fall before that? _____ Any care given? _____

What sports or recreational activities does he/she do? _____

When was the child's most recent stress, strain, or injury while doing these activities?
_____

Care given? _____

Has the child been involved in a motor vehicle accident as a passenger? Yes No

Briefly describe: _____

Any treatment received? _____ Chiropractic? _____

Does your child have any health concerns? _____

If so, for how long? _____

Are there any other conditions/illness that your child is or was experiencing?
_____

How long? _____

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. How often does your child have this condition? _____

Any medications? _____

Is there anything else that you feel is important that has not been addressed on this form?

Authorization

I the undersigned have read and answered the above information to the best of my knowledge. The above questions have been accurately answered on behalf of my child. I understand that providing incorrect information can be dangerous to my child's health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such said chiropractic care to third party payers and/or health practitioners. Providing my insurance provides for the care of my child, I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand, provided my insurance is accepted and provides for my child, that the carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of parent or legal guardian **Date**

Parental Consent

I, _____, hereby consent to Team Chiropractic permission to call my □ home, □ cell, and □ work number for appointment reminders and routine office needs regarding my child's account.

I hereby consent for Team Chiropractic to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

_____Relation: _____
_____Relation: _____
_____Relation: _____
_____Relation: _____

I hereby revoke any information to be given to the following family members regarding any routine office needs here at Team Chiropractic:

_____Relation: _____
_____Relation: _____
_____Relation: _____
_____Relation: _____

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

"I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein.

_____ _____
Patient Name, printed Legal Guardian/Parent Signature

_____
Date

PATIENT CONSENT

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

"I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein."

_____ _____

Patient Name, printed **Guardian Signature**

_____

Date

CHIROPRACTIC ORIENTATION

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. **Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.
Health: a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.
Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health-care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, _____, have read and fully understand the above statements.

_____ _____

Signature *Date*