

Childs' Name [Click here to enter text.](#)

# HEALING TOUCH CHIROPRACTIC

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Today's date:		Patient Number		(Office Use Only)	
<b>VITAL INFORMATION</b>					
Patient's Name					
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Height (of Child)	Weight(of Child)	Birth date:	Age:      Gender <input type="checkbox"/> M <input type="checkbox"/> F
Sibling Name	Age	Sibling Name	Age	Sibling Name	Age
<b>PARENT/GUARDIAN INFORMATION</b>					
Parent/Guardian Name					
ADDRESS					
Street		City	State	Zip	
<b>PARENT/GUARDIAN INFORMATION CONTINUED.</b>					
Parent/ Guardian Name					
ADDRESS					
Street		City	State	Zip	
Parent/Guardian Email		Home Phone: (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Cell Phone: (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Occupation	Parent/ Guardian Employer	Employer Phone: (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PARENT/GUARDIAN INFORMATION CONTINUED.</b>					
Parent/ Guardian Name					
ADDRESS					
Street		City	State	Zip	
Parent/Guardian Email		Home Phone (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Cell Phone: (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Occupation	Parent/ Guardian Employer	Employer Phone: (    )		May we leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	

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<b>ADDRESS</b>			
Street	City	State	Zip
How did you hear about us?		Other family members seen here: Y <input type="checkbox"/> N <input type="checkbox"/>	

**EMERGENCY CONTACT INFORMATION**

Emergency Contact			
Name	Relationship to Child	Phone Number (    )	Alternate Phone Number (    )

**FAMILY DOCTOR**

Name	Professional Designation	Clinic Name	Date of last visit	Reason for visit
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May we communicate with your family doctor?       Yes     No

**OTHER HEALTH CARE PROFESSIONALS**  
(MEDICAL SPECIALIST, NATUROPATHIC DOCTOR, HOMEOPATH, PT, OT, SPEECH PATHOLOGIST, MASSAGE THERAPIST, BEHAVIORAL THERAPIST, ETC.)

Name	Professional Designation	Clinic Name	Date of last visit	Reason for visit
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Why have you decided to have your child evaluated by a Chiropractor?

<input type="checkbox"/>	He / She is continuing ongoing care from another chiropractor.
<input type="checkbox"/>	I recently had my spine checked and understand the value in getting my child checked.
<input type="checkbox"/>	I have concerns about his/her health and I'm looking for answers.
<input type="checkbox"/>	He / She has a specific condition and I've learned that chiropractic may be able to help.
<input type="checkbox"/>	I want to improve my child's immune function.

## WELLNESS PROFILE

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine called the **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins, and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system - a condition called **Vertebral Subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's **ability to heal**.

### WHAT SIGNALS HAS YOUR CHILD'S BODY BEEN COMMUNICATING?

Previously	Currently		Previously	Currently		Previously	Currently	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive/Slow weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Slow or Absent Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Asymmetrical Crawling or Gait
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Challenges
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Torticollis/Head Tilt	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds/Croup	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Feeding on one side	<input type="checkbox"/>	<input type="checkbox"/>	Night Terrors
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tip Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Issues
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Red, Swollen, Painful Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tremors/Shaking
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>	Autism/SPD

Do you have a specific concern that brings you in?  Yes

No, I would like my child's nervous system assessed to achieve optimal health & functioning.

*If yes, please answer the questions:*

Does your child appear to be in pain or discomfort

Yes      No

For how long?

Is it:

Has it been:

Have you seen other health professionals regarding this complaint?

Yes    No   if Yes, whom?

What treatment did they use?

Has your child taken any medication for this complaint?

No

Yes

Childs' Name [Click here to enter text.](#)

Has your child ever experienced this complaint before?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Has your child received any treatment at this time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Has your child had x-rays in relation to the current complaint?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Has your child had any blood work done for the current complaint?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<b>PRENATAL PROFILE</b>			
<input type="checkbox"/> Adopted	<input type="checkbox"/> Prenatal history unknown		<input type="checkbox"/> Birth history unknown
			<b>Brief Description</b>
Complications during pregnancy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Ultrasounds during pregnancy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Medications during pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If so, which ones and how often? _____ _____ _____
Location of Birth: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Center <input type="checkbox"/> Other:			
Birth Attendants: <input type="checkbox"/> Doula <input type="checkbox"/> Midwife <input type="checkbox"/> GP <input type="checkbox"/> OB <input type="checkbox"/> Other:			
Medications during labor/ delivery (including IV antibiotics):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Was Pitocin used to induce / speed up labor?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Were your membranes ruptured by a medical professional?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Was your child at any time during your pregnancy in a constrained position?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure If Yes please describe: .
Was your delivery vaginal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How was the baby presented:
Was your delivery C- Section?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type of C-section
Were any medical interventions used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What Interventions were used
Were there any complications during delivery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain if other
Was the baby born with any purple markings / bruises on their face or head?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Any concerns about misshapen head at birth?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
How long was the labor from the first regular contractions to birth?			
How long was the second stage (the pushing phase) of the labor?			

POST NATAL & INFANT HISTORY				
How many weeks gestation was the baby at birth?	Weight	Length	Appgar 1 minute /10	Appgar 5 minutes /10
Was the baby ever admitted to the NICU?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How Long?	If yes, Why?
Was any medication given to the child at birth?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure	If yes, Why?
Was your child exclusively breastfed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months	
Was your child breastfed + formula fed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Months	
Did you introduce cereal or grains within your child's first year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Did your child spend a lot of time in any baby devices (bouncy swings, swings, bumbos, car seats, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Which ones?	
What age did you introduce solid foods?				
PHYSICAL TRAUMAS				
Has your child ever fallen from any high places?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has your child ever been involved in a motor vehicle accident?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has your child been seen on an emergency basis?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has your child broken any bones?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has your child had any previous hospitalizations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Has your child had any previous surgeries?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Does your child carry a back pack?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Does it weigh less than 15% of their body weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do they wear their back pack on 2 shoulders?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Does your child show excessive or uneven shoe wearing out?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Does your child wear custom orthotics?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Does your child use a tablet, computer, or video game?				
Does your child watch TV?				
Does your child exercise?				
Does your child play contact sports?				
Does your child sleep on their....				

CHEMICAL STRESSORS		
Have you chosen to vaccinate your child?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Reason to Vaccinate		
Reaction (s) to vaccination: <input type="checkbox"/> None <input type="checkbox"/> Fever <input type="checkbox"/> Diarrhea <input type="checkbox"/> Rash <input type="checkbox"/> Welt at injection site <input type="checkbox"/> Fatigue <input type="checkbox"/> Seizures <input type="checkbox"/> Prolonged Cry <input type="checkbox"/> Development Regression <input type="checkbox"/> Other .		
Does your child receive annual flu shots? <input type="checkbox"/> No <input type="checkbox"/> Yes (personal research) <input type="checkbox"/> Yes (MD Recommended)		
Has your child been exposed to antibiotics? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes how many doses in the past 6 months? Reason:		
Has your child been exposed to medications, including OTC? <input type="checkbox"/> No <input type="checkbox"/> Yes Yes If yes, which ones? If yes, how many doses in the past 6 months? Reason:		
How many glasses of water/day does your child have?	Choose an item.	
How many glasses of cow's milk, juice, and soda/ day?	Choose an item.	
Does your child eat gluten?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Trying to Eliminate	
Does your child eat dairy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Trying to Eliminate	
Any food/drink allergies or sensitivities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Is your child exposed to second hand smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child take a probiotic daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes	CFU's/day
Does your child take a vitamin D3 daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes	IU's/day
Does your child take Omega 3 fish Oils daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes	mg/day
Other supplements or homeopathics?		
EMOTIONAL STRESSORS		
Does your child seem happy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child show signs of depression or sadness?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child show signs of anxiousness or anxiety?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child participate in sports or extracurricular activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child have a high quality group of friends who have involved parents?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your family have regular family meals?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Has your child experienced bullying?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, share what action steps have been performed		
<b>AUTHORIZATION FOR CARE OF A MINOR</b>		
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.		
I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to check and adjust when appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.		
_____		____/____/____
<i>Patient/Guardian Authorizing Care Signature</i>		<i>Date</i>

**NOTICE OF HEALTH CARE AUTHORIZATION & PRIVACY POLICY**

I have been offered but have not made a request to review a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to Healing Touch to conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care.
- I give permission to use my physical address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If Healing Touch Chiropractic contacts me by my phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to Healing Touch Chiropractic to use my name and photograph on their welcome board, referral board, bulletin board and other informational material such as their brochure, website, social media sites and articles in print media.
- I give permission to Healing Touch to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, or their website, or in ads in print media.
- I give Healing Touch Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other person in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
- Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.
  - You may request restrictions on your disclosures
  - You may inspect and receive copies of your records within 30 days of a request
  - You may request to view changes to your record

By signing this form you are giving Healing Touch Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your Healing Touch Chiropractic more efficient and productive as well as to enhance your access to quality of Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Healing Touch Chiropractic plus 7 years unless revoked by me. I also understand that I can request, in writing, that you are restricting how my personal information is used and/or disclosed.

I have read and understand this Healthcare Form. My signature below represents agreement with these practices.

Name of Parent or Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Childs' Name [Click here to enter text.](#)

**OUR FEE STRUCTURE AND FINANCIAL POLICY**

**Please note our fees for your initial visit:  
Consultation, exam and nervous system scan: \$149**

**Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.**

**Also, note that the Report of Findings, the time that your doctor will spend with you to go over your results, is part of the initial visit fee. Recommendations for care are based on necessity and not insurance benefits. We are a cash office and are not in network with any insurance companies.**

**I CLEARLY UNDERSTAND AND AGREE that I am responsible for all the bills incurred at this office relating to my care. I also understand that if I suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable.**

I \_\_\_\_\_ have completely read and understood the above statement concerning fees and choose to receive care.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_