Childs' Name Click here to enter text.

HEALING TOUCH CHIROPRACTIC

DOWNLOAD BEFORE COMPLETING OR YOUR CHANGES WILL NOT BE SAVED!

Today's date:	Patient Number (Office Use Only)

VITAL INFORMATION

Patient's Name					
Previous Chiropractic Care? ☐Yes ☐ No	Height (of Child)	Weight(of Child)	Birth date:	Age:	Gender ☐ M ☐ F
Sibling Name Age	Sibling Name Age	Sibling Name Age			
ADDRESS Street	City	State	Zip		

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name			
ADDRESS Street	City	State	Zip
Parent/Guardian Email	Home Phone: ( )	May we leave a message ☐ Yes ☐ No	
	Cell Phone: ( )	May we leave a message ☐ Yes ☐ No	
Parent/Guardian Occupation	Parent/ Guardian Employer	Employer Phone: ( )	May we leave a message ☐ Yes ■ No

PARENT/GUARDIAN INFORMATION CONTINUED.

Parent/ Guardian Name			
Parent/Guardian Email	Home Phone ( )	May we leave a message ☐ Yes ■ No	
	Cell Phone: ( )	May we leave a message ☐ Yes ■ No	
Parent/Guardian Occupation	Parent/ Guardian Employer	Employer Phone: ( )	May we leave a message ☐ Yes ☐ No

Childs' Name Click here to enter text.

ADDRESS Street	City	State	Zip
How did you hear about us?	Other family members seen here: Y ☐N ☐		

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
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
Name	Professional Designation	Clinic Name	Date of last visit	Reason for visit

Why have you decided to have your child evaluated by a Chiropractor?	
☐	He / She is continuing ongoing care from another chiropractor.
☐	I recently had my spine checked and understand the value in getting my child checked.
☐	I have concerns about his/her health and I'm looking for answers.
☐	He / She has a specific condition and I've learned that chiropractic may be able to help.
☐	I want to improve my child's immune function.

Childs' Name Click here to enter text.

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

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?	☐ No	☐ Yes	
Has your child received any treatment at this time?	☐ No	☐ Yes	
Has your child had x-rays in relation to the current complaint?	☐ No	☐ Yes	
Has your child had any blood work done for the current complaint?	☐ No	☐ Yes	

PRENATAL PROFILE

☐ Adopted	☐ Prenatal history unknown	☐ Birth history unknown

			Brief Description	
Complications during pregnancy:	☐ No	☐ Yes		
Ultrasounds during pregnancy:	☐ No	☐ Yes		
Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:	☐ No	☐ Yes		
Medications during pregnancy	☐ No	☐ Yes		If so, which ones and how often?

Location of Birth: ☐ Home ☐ Hospital ☐Birth Center ☐Other:

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other:

Medications during labor/ delivery (including IV antibiotics):	☐ No	☐ Yes		
Was Pitocin used to induce / speed up labor?	☐ No	☐ Yes		
Were your membranes ruptured by a medical professional?	☐ No	☐ Yes		
Was your child at any time during your pregnancy in a constrained position?	☐ No	☐ Yes	☐ Unsure	If Yes please describe: N/A
Was your delivery vaginal?	☐ No	☐ Yes	How was the baby presented:	N/A
Was your delivery C- Section?	☐ No	☐ Yes	Type of C-section	N/A
Were any medical interventions used?	☐ No	☐ Yes	What Interventions were used	Explain if other N/A
Were there any complications during delivery?	☐ No	☐ Yes		
Was the baby born with any purple markings / bruises on their face or head?	☐ No	☐ Yes		
Any concerns about misshapen head at birth?	☐ No	☐ 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?				

Childs' Name Click here to enter text.

POST NATAL & INFANT HISTORY				
How many weeks gestation was the baby at birth?	Weight	Length	Apgar 1 minute 9 /10	Apgar 5 minutes /10
Was the baby ever admitted to the NICU?	☐ No	☐ Yes	How Long?	If yes, Why?
Was any medication given to the child at birth?	☐ No	☐ Yes	☐ Unsure	If yes, Why?
Was your child exclusively breastfed?	☐ No	☐ Yes	Months	
Was your child breastfed + formula fed?	☐ No	☐ Yes	Months	
Did you introduce cereal or grains within your child's first year?	☐ No	☐ Yes		
Did your child spend a lot of time in any baby devices (bouncy swings, swings, bumbos, car seats, etc.)?	☐ No	☐ Yes	Which ones?	
What age did you introduce solid foods?				

PHYSICAL TRAUMAS			
Has your child ever fallen from any high places?	☐ No	☐ Yes	
Has your child ever been involved in a motor vehicle accident?	☐ No	☐ Yes	
Has your child been seen on an emergency basis?	☐ No	☐ Yes	
Has your child broken any bones?	☐ No	☐ Yes	
Has your child had any previous hospitalizations?	☐ No	☐ Yes	
Has your child had any previous surgeries?	☐ No	☐ Yes	
Does your child carry a back pack?	☐ No	☐ Yes	
Does it weigh less than 15% of their body weight?	☐ No	☐ Yes	
Do they wear their back pack on 2 shoulders?	☐ No	☐ Yes	
Does your child show excessive or uneven shoe wearing out?	☐ No	☐ Yes	
Does your child wear custom orthotics?	☐ No	☐ Yes	
Does your child use a tablet, computer, or video game?	Several hrs/day		
Does your child watch TV?	Several hrs/day		
Does your child exercise?	Seasonally		
Does your child play contact sports?	Seasonally		
Does your child sleep on their….	Both Sides		

Childs' Name Click here to enter text.

CHEMICAL STRESSORS			
Have you chosen to vaccinate your child?	☐ No	☐ Yes N/A	Reason to Vaccinate
Reaction (s) to vaccination: ☐ None ☐ Fever ☐ Diarrhea ☐ Rash ☐ Welt at injection site ☐ Fatigue ☐ Seizures ☐ Prolonged Cry ☐ Development Regression ☐ Other .			
Does your child receive annual flu shots? ☐ No ☐ Yes (personal research) ☐ Yes (MD Recommended)			
Has your child been exposed to antibiotics? ☐ No ☐ Yes. If yes how many doses in the past 6 months? Reason:			
Has your child been exposed to medications, including OTC? ☐ No ☐ 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?	0		
How many glasses of cow's milk, juice, and soda/ day?	0		
Does your child eat gluten?	☐ No ☐ Yes ☐ Trying to Eliminate		
Does your child eat dairy?	☐ No ☐ Yes ☐ Trying to Eliminate		
Any food/drink allergies or sensitivities?	☐ No ☐ Yes		
Is your child exposed to second hand smoke?	☐ No ☐ Yes		
Does your child take a probiotic daily?	☐ No ☐ Yes	CFU's/day	
Does your child take a vitamin D3 daily?	☐ No ☐ Yes	IU's/day	
Does your child take Omega 3 fish Oils daily?	☐ No ☐ Yes	mg/day	
Other supplements or homeopathics?			

EMOTIONAL STRESSORS	
Does your child seem happy?	☐ No ☐ Yes
Does your child show signs of depression or sadness?	☐ No ☐ Yes
Does your child show signs of anxiousness or anxiety?	☐ No ☐ Yes
Does your child participate in sports or extracurricular activities?	☐ No ☐ Yes
Does your child have a high quality group of friends who have involved parents?	☐ No ☐ Yes
Does your family have regular family meals?	☐ No ☐ Yes
Has your child experienced bullying?	☐ No ☐ Yes
If yes, share what action steps have been performed	

AUTHORIZATION FOR CARE OF A MINOR

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.

_____/_____/_____

Patient/Guardian Authorizing Care Signature ***Date***

Childs' Name Click here to enter text.

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. You can request a copy of the Privacy Practices in it's entirety at any time. 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** _____/_____/_____

OUR FEE STRUCTURE AND FINANCIAL POLICY

Please note our fees for your initial visit:
Consultation, exam and nervous system scan: $95

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 _____/_____/_____