PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ______________________________ S.S.#: ______________________

Address: ______________________________ City: ______________________

State: ____________ Zip: __________ Home Phone: ______________________

Birth Date: _____ / _____ / _____ Work Phone: ______________________

Sex: ________ Weight: ________ Height: ________ Referred By: ______________________

Names of Parents / Guardians: ______________________________

Purpose For Contacting Us ? ______________________________

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: ______________________

____

Other Health Problems ? ______________________________

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing / Back Pains
- ☐ Other ____________

Family History: ______________________________

Previous Chiropractor: ______________________________

Date of Last Visit: _____ / _____ / _____ Reason: ______________________

Name of Pediatrician: ______________________________

Date of Last Visit: _____ / _____ / _____ Reason: ______________________

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: ______________________

Vaccination History: ______________________________

Prenatal History:

Name of Obstetrician / Midwife: ______________________________

Complications During Pregnancy ? _____ N _____ Y , List: ______________________

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: ______________________

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _______ Forceps _______ Vacuum Extraction

_______ Ceasarian Section , Emergency or Planned ?

Complications During Delivery ? _______ N _______ Y , List: _______

Genetic Disorders or Disabilities: _______ N _______ Y , List: _______

Birth Weight: _______ Birth Length: _______ APGAR Scores: _______ , _______

Feeding History:

Breast Fed: _______ N _______ Y , How Long: _______

Formula Fed: _______ N _______ Y , How Long: _______ Type: _______

Introduced to Solids at: _______ Months , Cows' Milk at _______ Months

Food / Juice Allergies or Intolerances: _______ N _______ Y , List: _______

____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropract for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_______ Respond to Sound

_______ Respond to Visual Stimuli

_______ Hold Head Up

_______ Sit Up

_______ Cross Crawl

_______ Stand Alone

_______ Walk Alone

According to the National Saftey Council, approximately 50% of children fall head first from a high place during their first year of li (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _______ N _______ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _______ N _______ Y , List: _______

____

Has Your Child Ever Been Involved in a Car Accident ? _______ N _______ Y , List: _______

Has Your Child Been Seen on an Emergency Basis ? _______ N _______ Y , List: _______

Other Traumas Not Described Above ? _______ N _______ Y , List: _______

Prior Surgery: _______ N _______ Y , List: _______

Menarche: _______ N _______ Y , Age: _______

Childhood Diseases:

Chicken Pox	N / Y, Age _______	Mumps	N / Y, Age _______
Rubella	N / Y, Age _______	Whooping Cough	N / Y, Age _______
Rubeola	N / Y, Age _______	Other	N / Y, Age _______

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understa and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _______ Policy #: _______

Signed: _______ Witnessed: _______ Date: ____ / ____ / ____

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OUR FINANCIAL POLICY

Thank you for choosing us as your Chiropractic health care provider. We are committed to your treatment being successful. The following is a statement of our *Financial Policy*, which we require you read, and sign prior to any treatment.

Patients

All Patients are responsible for payment at the time of service. It is requested that 100% of your first visit be paid at the time of your visit.

New Patient Appointments: range in prices depends on the time required and the condition of the patient. The fees account for the scope of assessment, depth of case management, and services rendered. I customize my services for each patient, so I will determine the specific time and cost for these appointments. I reserve the right to provide an alternative fee schedule based upon whether we are providing services to an individual/pregnant mom/kids/family all at once.

Payment and Billing

I do accept insurance if they accept me and I will work to get your services covered based on your plan. Patients are responsible for all charges. Payments for services are accepted and processed by check, cash, or debit/credit card on the patient's file. For your convenience, we accept all credit cards.

Missed Appointments and Fees

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of **24 hours in advance** if you are unable to do so.
At Dr. Val Chiropractic, your scheduled appointment time is reserved just for you. We do not overbook appointment times in order to provide you with personalized and quality care.

Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment**: Our staff will call to reschedule your next appointment. We understand things happen and you will not be billed for your first missed appointment.
- **Second missed appointment**: You will receive a note via e-mail/mail/text **(select which you prefer)** stating this is your second missed appointment and that you have been charged a **cancellation fee. A fee of $40 will be charged** as well as a credit card kept on file for any future missed appointments that are cancelled or rescheduled with less than 24-hour's notice.

We offer several methods of payment for our Chiropractic care at our office. Please read carefully and choose the plan, which applies, to you. Our main concern is your health and well being, and we will do our best to help accommodate and serve you.

______ **PLAN #1** INSURANCE – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance information, on or before your second visit. Until we have verified your Chiropractic coverage, you will be required to pay for your care. Most patients will pay a co-pay, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Remember, insurance companies balk at "maintenance" and "long-term rehabilitation." Most "health" policies are designed and intended to only take care of acute problems, they want you to eventually "get off" insurance. At this point, we will present affordable cash plans.

______ **PLAN # 2** CASH – Fees are to be paid at the time services are rendered or prior. After payment for the initial visit, you will only be responsible for payments for all future services.

Professional Fees are as follows:

1. Comprehensive Initial Exam/X-rays — $70-$350
2. Established Patient Office Visit/Re-exam — $50-$150
3. Full Spine/Extremity Spinal Manipulations — $65- $140
   a. Pediatric 0-10 yrs. — $25
   b. Pediatric 11-18 yrs. — $35
4. Deep Muscle Stimulation — $25
5. Myofascial Release — $25
6. Kinesiology Taping — $25
7. Therapeutic Exercise/Stretching/Rehabilitation — $25
8. Instrument Assisted Soft Tissue Mobilization — $25
9. Radiology Report Second Opinion — $30
10. Craniosacral Therapy — $68

______ **PLAN # 3** AUTO INJURY – You will supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until the insurances are verified, you will be required to pay for your care. We will bill your insurance directly after we verify coverage.

______ **PLAN #4** MEDICARE – Per established Medicare guidelines, please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. In the event the check should come to you. You are expected to bring the check to us.

Patient Accountability

You are expected to be an active participant in your care. Your chiropractor's recommended treatment plan, exercises, stretches, ice/heat applications, life-style changes, or other active processes must be followed to ensure optimum progress.

I have read and understand this Policy Agreement.

By signing below, I will abide by its terms.

Patient Name: ______________________________ Date: ____________

Patient Signature: __________________________

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ______________________ Date:

Parent or Guardian: ______________________ Signature: ______________________ Date:

Witness Name: ______________________ Signature: ______________________ Date: