



Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Birth Date: _____ Age: _____ Sex: M F

of Siblings: _____

Sibling's Names & Ages: _____

Parents' Names: _____

Best Contact Phone: () _____

Alternate Phone: () _____

Email: _____

Who can we thank for referring you or how did you hear about Cedar Chiropractic? _____

REASON FOR SEEKING CARE

If there is one thing we can solve for your child today what would that be? _____

What happened recently that made this your primary concern? _____

Are there any major injuries and/or surgeries we should know about? _____

Has your child seen any other providers for this condition? (List all that apply) _____

How is this affecting your child's lifestyle (home, school, socially)? _____

On a scale of 1 to 10, how big is this issue impacting your daily life? 1 2 3 4 5 6 7 8 9 10

In spending 30 minutes with you and your child today, how committed are you at getting your child's health concerns resolved?

I want to get an agreement with you, that you will spend the next 30 minutes with me to see if we can help your child.

If you agree, how committed are you to getting this resolved?

(not at all) 0 1 2 3 4 5 (all in)

HEALTH CONCERNS

- | | |
|--|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Asthma/Chronic Bronchitis |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Colic/Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/Neck Pain/Stiffness |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Difficulty Gaining Weight |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Ear or Infections |
| <input type="checkbox"/> Frequent Sickness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Learning Disorders |
| <input type="checkbox"/> Detachment/Distant | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability/Nervous | <input type="checkbox"/> Autism/Asperger's |

- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

Is there anything else regarding your current condition you feel the doctor should know? _____

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digestive |

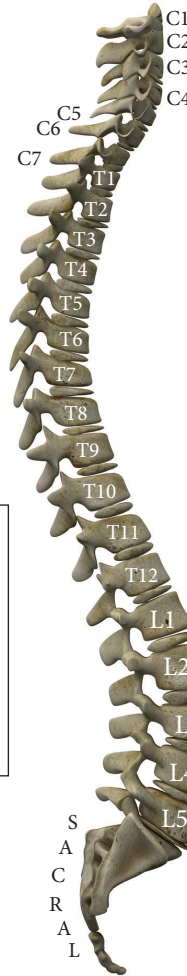
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

Did you know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
ADD / ADHD
Difficulty Concentrating
Autism

Constipation
Colitis
Infertility
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

Middle Back Pain
Congestion
Difficulty Breathing
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

VITAMIN / SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega 3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above:

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery:

C-section delivery - Doctor pulled or twisted baby - Anaesthesia - Labor was induced

Forceps/vacuum extraction - Premature delivery - Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

Did you experience any illness while pregnant? Yes No If yes, explain: _____

Do you have any physical disabilities? Yes No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? Yes No Number of times: _____

Did you formula-feed or breastfeed your baby? Formula Breastfeed How long: _____ Formula Brand: _____

At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child exercise daily? Yes No How much? _____

Does your child drink soda? Yes No How much/often? _____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much? _____

Does your child eat balanced meals? Yes No

Does your child experience prolonged sadness? Yes No Explain: _____

Does your child have difficulty sleeping? Yes No Explain: _____

Does your child play video games? Yes No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No Explain: _____

Has your child ever been hospitalized or had surgery? Yes No Explain: _____

Does your child have difficulty interacting with others? Yes No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain: _____

Has your child been involved in any high impact/contact sports (soccer, football martial arts, cheerleading, etc.)? Yes No

Please list: _____

Are you aware of any food allergies or intolerance? Yes No Explain: _____

Has your child received all recommended vaccinations? Yes No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 4 5 6 7 8 9 10 Personal: 1 2 3 4 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Cedar Chiropractic permission to examine, x-ray (if necessary), and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose 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 with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as a quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____ Relationship to Patient: _____

FINANCIAL POLICY

Our Goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Cedar Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment so Cedar Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me to Cedar Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Cedar Chiropractic authority to endorse and cash checks, drafts or money orders made payable to the undersigned or as c-payee with this clinic for payments due for services rendered on behalf of the undersigned by Cedar Chiropractic.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment for non-coverage, deductible, and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date: _____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Cedar Chiropractic to treat my condition as deemed appropriate. At Cedar Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Cedar Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____