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PATIENT INFORMATION

Patient Name _____

Address _____ Apt _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Mother's Name _____

Mother's Occupation _____

Mother's Phone _____

Mother's Email _____

Father's Name _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

_____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting

❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech

❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

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GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- ❑ Chicken Pox
- ❑ Measles
- ❑ Rubeola
- ❑ Mumps
- ❑ Rubella
- ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- ❑ Allergies
- ❑ Anemia
- ❑ Arm Problems
- ❑ Asthma
- ❑ Back Aches
- ❑ Bed Wetting
- ❑ Behavioral Problems
- ❑ Broken Bones
- ❑ Chronic Ear Aches
- ❑ Colds/Flu
- ❑ Colic
- ❑ Convulsions/Seizures
- ❑ Delayed Speech
- ❑ Diabetes
- ❑ Digestive Issues (constipation/diarrhea)
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Heart Trouble
- ❑ Hyperactivity
- ❑ Hypertension
- ❑ Jeuvenile Rheumatroid Arthritis
- ❑ Joint Problems
- ❑ Leg Problems
- ❑ Neck Problems
- ❑ Neuritis
- ❑ Orthopedic Problems
- ❑ Paralysis
- ❑ Poor Appetite
- ❑ Ruptures/Hernias
- ❑ Sinus Trouble
- ❑ Tuberculosis
- ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

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Have you experienced chiropractic care before? Yes / No	If yes, was it a positive / negative or neutral experience?					
What percent of your diet consists of fruits and vegetables?	%					
How many ounces of water do you consume on average, daily?	ounces					
How much protein do you consume?	None /	Once in a while /	Weekly /	Daily /	Multiple times per day	
How much dairy do you consume?	None /	Once in a while /	Weekly /	Daily /	Multiple times per day	
How much alcohol do you consume?	None /	Once in a while /	Weekly /	Daily /	Multiple times per day	
Do you smoke?	None /	Once in a while /	Weekly /	Daily /	Multiple times per day	
Do you exercise?	None /	Once in a while /	Weekly /	Daily /	Multiple times per day	
Are you healthier now than you were 5 years ago?						
List any surgeries:						
Any family history of?	Diabetes / Heart Disease / Cancer / Rheumatoid Arthritis / High Blood Pressure					
When do you generally feel your worst?	A.M / Noon / P.M.					
Do you own a juicer?	If so, how often do you juice? Monthly / Weekly / Daily / Multiple times per day					
How committed to your health are you?	Not 1 2 3 4 5 6 7 8 9 10 Extremely					

Almost done! Lastly, we want to be absolute certain that agreements are in place in order to avoid any disagreements…

ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT
I hereby consent to a chiropractic evaluation and examination, x-ray(s), chiropractic treatment(s), decompression, k-laser, supplements, healthy lifestyle information (books, CD's, DVD's etc), or activities of daily living information rendered to the client which our doctors may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Stanlick Chiropractic. I hereby authorize the above named doctor(s) to release information requested on this form and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I know I am responsible for payment of my account and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductibles, coinsurances and co-pays are my responsibility to pay.

TERMS
Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1 ½ per month (annual percent rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

NOTICE OF PRIVACY PRACTICES
The federal government has passed the Health Insurance Portability and Accountability Act ("HIPAA") to protect your Personal Health Information ("PHI"). HIPAA took effect on April 14, 2003. Implementation of and compliance with HIPAA is not an option for Stanlick Chiropractic.

Sign below indicating that you have had the opportunity to receive a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will need an Acknowledgement Form signed by you on behalf of the patient.

By signing below I acknowledge that I have received and reviewed the Privacy notice of: Stanlick Chiropractic and all my questions have been answered to my satisfaction in language that I can understand.

Signature _____ Date _____

Relationship _____

Witness _____

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CONSENT FOR CHIROPRACTIC CARE

I hereby request that Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Steven Rawson, D.C., and/or Taylor Marsh, D.C., provide chiropractic services for me (or my minor child, whose name appears below). I understand that the care is to be provided by Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Steven Rawson, D.C., and/or Taylor Marsh, D.C., or designated assistant. Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Steven Rawson, D.C., and/or Taylor Marsh, D.C., has discussed my care with me and I understand that:

1. The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.

2. Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore diagnosis of medical conditions is not a primary goal. However, I will be informed of abnormal findings.

3. Chiropractors do not give medical advice, nor do they discourage me from receiving medical advice. If deemed advisable, Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Steven Rawson, D.C., and/or Taylor Marsh, D.C., will refer me for medical services with all possible diligence

4. Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Steven Rawson, D.C., and/or Taylor Marsh, D.C., uses only chiropractic methods that are taught in accredited colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.

5. Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.

6. Although the risks are very minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.

7. Because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.

8. I am an active participant in my chiropractic care, and I am therefore invited to ask any questions or express any concerns that I may have.

9. I am free to withdraw my consent and discontinue care at any time.

CONSENT TO EVALUATE AND TREAT A MINOR

By signing below, I, _____ being the parent / legal guardian of _____

do hereby grant permission to the treating staff doctor, to perform chiropractic services to the minor listed above.

I have read the above statements and understand Stanlick Chiropractic's objectives pertaining to my care in this office.

Signature _____ Date _____

Witness _____ Date _____

Witness (printed) _____