CONFIDENTIAL PEDIATRIC HEALTH RECORD

Today's Date: _____ Email Address: _____

Child's Name: _____Middle: _____ Last: _____

Child's Date of Birth: _____ Age: (years) _____ (months) _____ Sex: **M F**

Parent/Guardian Names: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D**

Social Security Number: _____

Your Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of Significant Other: _____ Significant Other Date of Birth: _____

Number of Children: _____Names of Children: _____

Name of Family Doctor: _____ Doctor Phone: _____

Were you referred by another health care professional? **Yes No** Whom? _____

Whom may we thank for referring you to our office? _____

Have you ever received chiropractic care? **Yes No** Date of last visit: _____

Has your child ever received chiropractic care? **Yes No** Date of last visit: _____

Name of previous Chiropractor: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

CURRENT HEALTH CONDITION:

Describe the major complaint(s)/reason(s) that brings you and your child to our office: _____

_____

_____

When did this start? _____ Has he/she had this before? **Y N**

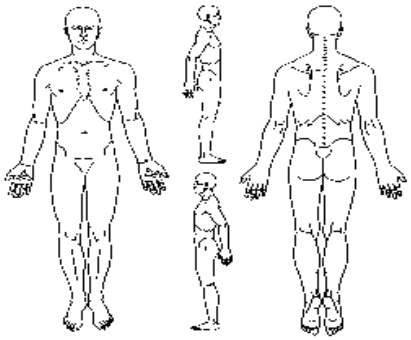
What do you feel caused this problem? _____

Type: **Pain Numbness Swelling Muscle Spasms Headache Tightness Stiffness Tingling Weakness**

Quality: **Sharp Dull Aching Throbbing Crushing Stabbing Local Radiating Burning Migraine Tension Hormonal Sinus Organic**

On a scale of 1-10 circle the number that represents the severity of your pain:	
NO PAIN	**0**
MILD PAIN	**1 2 3**
MODERATE PAIN	**4 5 6**
SEVERE PAIN	**7 8 9**
DISABLING PAIN	**10**

Indicate where your pain is located with an "X":



Is the Pain: **Constant Frequent Intermittent Occasional Infrequent**

Is this condition due to an accident? **Yes No**

Explain accident: _____

_____

_____

Circle the activities/movements below that are painful for your child to perform?

Sitting Standing Walking Bending Lying Down Other: _____

What activities make your child's condition/pain better? _____

_____

Is this condition worse during certain times of the day? **Yes No** When? _____

Is this condition interfering with **Activities Sleep Routine Other:** _____

Is this condition getting progressively worse? **Yes No**

Has your child seen anyone else for this? **Yes No** Who? _____

Explain previous and current care for this problem: _____

_____

_____

Is your child taking any medications for this problem? **Yes No** _____

_____

FORTIFY CHIROPRACTIC
460 Main St. W. • Rainsville, AL 35986 • 256-638-4228

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LABOR AND DELIVERY HISTORY:

Most people experience their first subluxation (nerve system interference) during the birth process, how do you recall the child's birth?

☐ Vaginal Delivery	☐ Planned C-Section	☐ Emergency C-Section	
☐ Hospital Birth	☐ Home Birth	☐ Midwife Assisted	☐ Birth Center
☐ Birth Induced (Pitocin)	☐ Forceps Delivery	☐ Vacuum Extraction	
☐ Anesthesia Administered	☐ Fetal Distress	☐ Meconium Staining	
☐ Head Presentation	☐ Face Presentation	☐ Breech Presentation	

Birth details: _____

_____

Were there any pregnancy problems? _____

_____

Labor or delivery problems? _____

_____

Congenital defects or anomalies? _____

_____

PAST MEDICAL HISTORY:

Has this child had any surgeries? **Yes** **No** If yes, please explain: _____

_____

Does this child currently take any medications? **Yes** **No** If yes, please list: _____

_____

Has this child suffered any severe accidents? **Yes** **No** If yes, please explain: _____

_____

Pediatrician/Family MD's Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Office Phone: _____

PAST HEALTH HISTORY:

For the following conditions, please circle **O** for previously had or **Δ** for currently have…

O Δ Headaches
O Δ High Blood Pressure
O Δ Low Blood Pressure
O Δ Back Pain
O Δ Diarrhea
O Δ Arthritis
O Δ Fatigue
O Δ Depression
O Δ Broken Bones
O Δ Abnormal Sugar Levels
O Δ Orthopedic Problems
O Δ Rheumatic Fever
O Δ Convulsions/Seizures
O Δ Sinus Troubles
O Δ Decreased Energy
O Δ Attention Problems
O Δ Growing Pains
O Δ Colds/Flu
O Δ Neck Pain
O Δ Sleeping Problems
O Δ Hyperactivity
O Δ Leg Problems
O Δ Joint Problems
O Δ Digestion Problems
O Δ Constipation
O Δ Decreased Energy
O Δ Poor Appetite
O Δ Ruptures/Hernias
O Δ Behavioral Problems
O Δ Coordination Problems
O Δ Walking Problems
O Δ Other:_____
O Δ Fainting
O Δ Dizziness
O Δ Heart Problems
O Δ Arm Problems
O Δ Allergies
O Δ Muscle Jerking
O Δ Irritability
O Δ Anemia
O Δ Earaches
O Δ Paralysis
O Δ Tension
O Δ Stiff Neck
O Δ Bed Wetting
O Δ Asthma
O Δ Neuritis

FAMILY HEALTH HISTORY:

Does any member of your family suffer from your current condition? **Yes No** Whom? _____

Any other pertinent family history/conditions: _____

Is there a family history of: **Heart Disease Cancer Arthritis Diabetes Other:**_____

Is there anything else we should know about your child? **Yes No** _____

_____

Parent/Guardian Signature: _____ **Date:** _____

Patient ID: _____

PAYMENT INFORMATION RECORD

Patient Name: _____

Date of Birth (M/D/Y): _____Social Security Number: _____

Please check one:

[ ] Yes, I have insurance that I would like verified. I am providing Focused on You Chiropractic with my insurance information.

[ ] No, I do not have any insurance that I would like verified.

Subscriber's First Name: _____ Last Name: _____

Subscriber's Date of Birth (M/D/Y): _____Social Security Number: _____

Subscriber's Employer: _____Occupation: _____

Work Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Insurance Co: _____ Phone Number: _____

Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Secondary Insurance Co: _____ Phone Number: _____
Address: _____

Group Number: _____ Policy Number: _____

Who is responsible for this account? _____ Relationship to Patient: _____

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance companies listed above and assign directly to **Fortify Chiropractic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Fortify Chiropractic** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____Date:_____

Pregnancy Release: Informed Consent to X-ray

To be completed on day of x-ray, if x-rays are to be taken.

All women of childbearing age must sign this release and check the appropriate category.

"This is to certify that, to the best of my knowledge, I am not pregnant. The images radiology consultant and/or doctor has my permission to take x-rays. I will assume all responsibility for all effect on a fetus potentially present."

[ ] I am presently using birth control pill, contraceptive, or an IUD as a form of birth control

[ ] I have started my menstrual period in the last 10 days
Date: _____

[ ] I have had a hysterectomy or tubal ligation

[ ] I am presently in menopause or post-menopause

[ ] Other
Please Explain: _____

[ ] None of the above

Patient Name: _____

Signed: _____

Date: _____

Witness Name (if applicable): _____

Signed: _____

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I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic at Fortify Chiropractic or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor at Fortify Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic at Fortify Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other mealth modalties, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issues. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surger. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatent options.

I have read, aor have had read to me, the above concent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient or Guardian:_____

Date:_____

Printed Name of Guardian and Relationship:_____