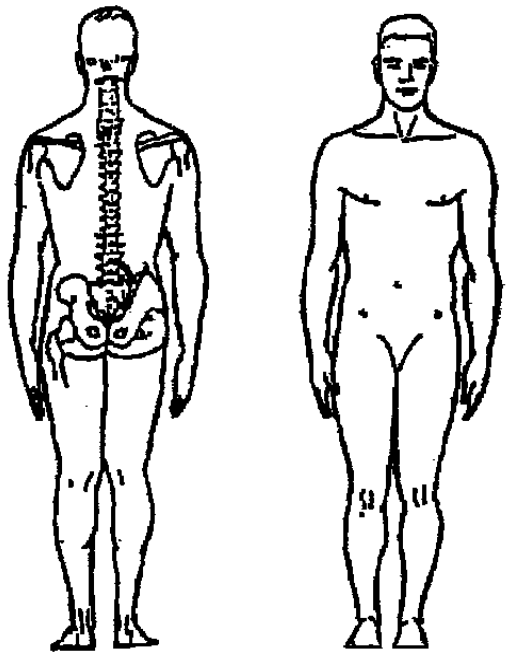
PEDIATRIC INFORMATION/APPLICATION FOR CARE (CHILDREN AGES 12 AND UNDER)

3.The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**.

Child's Name _____ Nickname: _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Child's Social Security # _____

Name of Parent or Guardian_____ Their Phone Number_____ Their Birthdate_____
Referred to our office by: _____

Please describe the major concerns and mark them on the diagram →



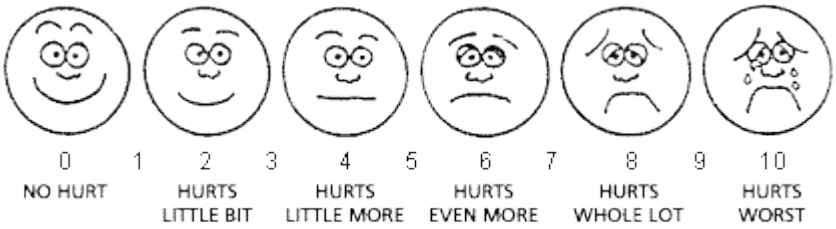
_____
_____

A. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

B. Frequency
- ☐ Constant (75-100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (25 - 50%)
- ☐ Intermittent (25% or less)

C. How long have you been experiencing these symptom(s)
- ☐ Days ☐ Months
- ☐ Weeks ☐ Years
- How many? _____

D. On the scale below indicate the intensity of your pain at its lowest and highest level:



D. Your symptoms are: _____decreasing _____not changing _____increasing
E. Symptoms are worse in the: _____Morning _____Night _____Increases during the day _____Same all day

Is condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Notice to our New Patients: *Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.*

Patient or Guardian Signature _____ Date _____

CONFIDENTIAL PATIENT CASE HISTORY PEDIATRICS

Dear Parent/Guardian: Please complete this questionnaire. The answers will help us determine if chiropractic can help. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Patient Name _____ Date _____

Please check the appropriate box for any of the following symptoms which patient may now have or have had previously. We want all the facts about the patient's health before we accept their case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders

Pain or numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE, & THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS THE PATIENT HAS HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough

What is the main goal in seeking care in our clinic? _____

_____

Type of Birth of patient:
☐ Vaginal ☐ C-Section ☐ Forceps ☐ Suction Cap/Vacuum
Any complications during pregnancy or birth? _____

_____

What makes condition(s) *better*?
☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____
What makes condition(s) *worse*?
☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

Has patient seen another health care provider for this condition(s)? ☐ No ☐ Yes Type of provider(s) seen _____

Diagnosis and treatment received to date for this condition(s)? _____

List surgical operation(s) and year(s): _____
_____
Drugs patient now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills
Others: _____
Has patient been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____
Has patient ever had any mental or emotional disorders? ☐ Yes ☐ No Explain _____
Have others in your family had such disorders? ☐ Yes ☐ No Explain _____

HAS PATIENT EVER:	Yes	No	**DESCRIBE BRIEFLY**
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DOES PATIENT:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend *not living in your home*):

NAME _____

ADDRESS: _____ **PHONE:** _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS- Dr. David Cartwright

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now, or in the future, work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To the best of my knowledge I am NOT pregnant and the above-named Doctor has my permission to x-ray me for diagnostic interpretation.

Patient's Signature **Date**

OFFICE FINANCIAL POLICY

- Payment is due the day service is provided unless other payment arrangements have been made with staff.
- Please communicate with the front desk staff whether you will be filing claims to an insurance company, and present your current insurance card to the front desk. If at any time you change insurance companies, please notify the front desk immediately to update your records.
- **Our doctor is not in any one network. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to find out the coverage under your plan. Any quote of eligibility and benefits is not a guarantee of payment.**
- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly contact your insurance company, adjustor, or agent. Your insurance is an agreement between you and your insurance company.
- If the patient discontinues care for any reason or completes care, payment is due in full on all services rendered.
- In accordance with Medicare Law, our office cannot give any special promotions or offers to patients who receive Medicare benefits.
- ***If given less than 48 hours notice you will be expected to pay a missed appointment fee of $25.***
- ***For the appointments that are given no notice those are considered no-call-no-shows be expected to pay a missed appointment fee of $35.***

I have read and understand the Office Financial Policy and agree to abide by these terms.

Patient's Signature **Date**

CONFIDENTIALITY AND SECURITY
Falls Clinic of Chiropractic

Falls Clinic of Chiropractic's Doctor and employees will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Falls Clinic of Chiropractic's patients. Falls Clinic of Chiropractic maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our patient information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, Falls Clinic of Chiropractic limits access to our patient's information to only those Doctors and employees who need access to the information to perform their job functions. Doctors and/or employees who misuse information are subject to disciplinary actions. Externally, we do not disclose patient information to any third parties unless we have previously informed the patient of the disclosure, have been authorized to do so by the patient, or are required or permitted to make the disclosure by law or our regulations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

HIPAA Release Form

I authorize the release of information including the diagnosis, records, examinations rendered to me, and claims information. This information may be released to the following people (please provide their names and relation):

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

Messages from Falls Clinic of Chiropractic

Please call:

[ ] my cell_____
[ ] my work_____
[ ] my home_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

I, _____ (print name), acknowledge receipt of Falls Clinic of Chiropractic's Confidentiality and Security form and I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. This copy will be kept in my patient folder.

_____ _____

Patient Signature **Date**