Health First Chiropractic & Wellness Center

PATIENT INFORMATION (6 Years to 17 years)

Please print clearly:

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

DATE OF BIRTH: _____/_____/_____ M / F

PARENT NAME: _____

PARENT CELL #: (_____) _____- _____

PARENT E-MAIL: _____

SIBILINGS and AGES:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

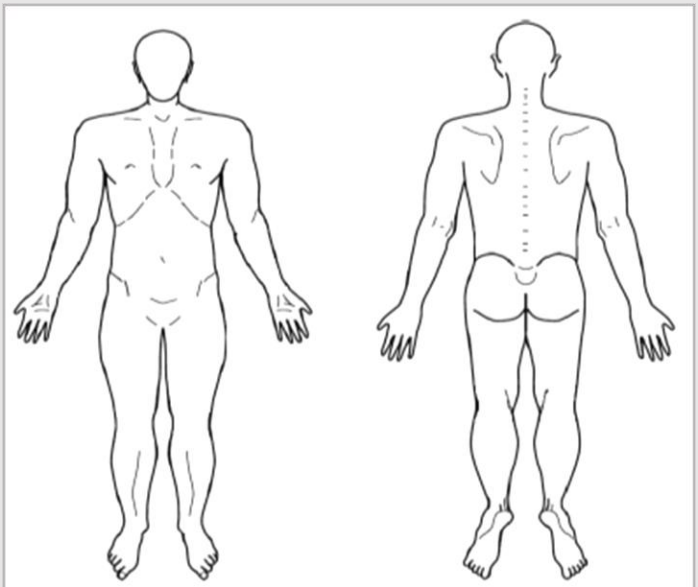
REGULAR PEDIATRICIAN:

_____

PHONE #: (_____) _____ - _____

To Whom may we thank for referring you?

_____



Primary reason you are seeking our help:

_____

_____

If you have any specific areas you would like us to address, please mark the area of concern on the above diagram.

How long has your child had this problem?

_____

Has your child been seen by a chiropractor before?

YES / NO

If yes, Who? _____

Reason for care? _____

_____

Were x-rays taken? YES / NO

Approximate dates of care: _____

_____

MEDICAL HISTORY:

List all operations for your child and approximate dates:

_____

_____

List all medications your child is currently taking and why:

1. _____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

FEMALES ONLY:

Could your child be pregnant? YES / NO When was her last period? _____

Please list any concerns you feel we need to know about: _____

WHY WE CHECK CHILDREN

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and stress on this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

Today will help reveal the causes of any Vertebral Subluxations which may interfere with the optimal function of your child's nervous system and therefore impair your child's inborn ability to be healthy.

CORRECTION

Today, we are becoming more aware, how modern lifestyle choices expose our children's nervous systems to a variety of stresses.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider trained and qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the chiropractic adjustment is the beginning of greater health and well-being for your child.

I, _____ (parent/legal guardian) understand this office is not offering to treat symptoms and disease. I understand the purpose of _____ (minor's name) examination is to determine how to improve the overall health of their spine and nervous system. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I hereby authorize the doctors at Health First Wellness Center and/or their assistants to perform my initial health examination and the doctors to administer care as deemed necessary to my child. I certify that the information in this entire intake form is true and correct.

_____ _____

Parent / Legal Guardian Signature Date

_____ _____

Printed Name Relationship

Health First Chiropractic & Wellness Center
530 Madison Street - St. Charles, MO 63301
(636) 946-3600

HEALTH HISTORY: 6 Years to 17 Years

About Your Child's Health - In the past year have you had any of the following:

Back or neck pain? YES / NO
Pains in the legs or arms? YES / NO
Headaches? YES / NO If YES, how often: _____
Asthma? YES / NO
Earaches? YES / NO If YES, how often: _____
Falls from bicycle, skateboard, scooter, rollerblades, or similar? YES / NO
Do you ever have a problem with bedwetting? YES / NO
Have you ever been in a motor vehicle accident? YES / NO
Have you had any broken bones? YES / NO If YES, describe: _____
Do you have any other health problems? YES / NO If YES, describe: _____

About Your Lifestyle

How do you carry your schoolbooks? _____
How heavy is your schoolbook bag/backpack? _____
What sports do you play? _____
What hobbies do you have? _____
How many hours a day do you watch TV? _____
How many hours each day do you spend using a computer, tablet or phone? _____
How many hours each day do you spend playing video games? _____
On average, how many hours of sleep do you get each night? _____
Are there any smokers in your family? YES / NO
Do you feel stressed out? YES / NO If YES, describe: _____
Do you have trouble reading the board in class? YES / NO
Do you ever have blurred vision? YES / NO
Do you wear glasses or contacts? YES / NO
Do you sometimes get headaches when you read? YES / NO

About Your Diet

What do you usually eat for breakfast? _____
What do you usually eat for lunch? _____
What do you usually eat for dinner? _____
What snacks do you have after school? _____
What is your favorite food? _____
How much water do you drink each day? _____
How many sodas, energy, or sports drinks do you drink each day? _____
How often do you eat fast food? _____
Do you take vitamins? YES / NO
How much cow's milk do you drink each day? _____

For Parents:

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effect from interfering with this process with artificial immunizations are just being uncovered.

Did your child experience any behavioral, emotional or physical changes within 3 months of any shots? YES / NO
If YES, Please describe: _____
Was it reported to your doctor? _____

Health First Wellness Chiropractic Clinic

Palmer Specific Chiropractic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND
(Patient's Name)

AGREE AS FOLLOWS:

1. The Practice's Privacy notice will be offered to me (upon request) prior to my signing this Consent. The Privacy notice includes a complete description of the uses and /or disclosures of my *protected health information* ("PHI") necessary for the Practice to provide treatment of me, and also necessary for the Practice to obtain payment of that treatment and to carry out its' health care operations. The practice explained to me that the Privacy notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its' privacy practices that are described in its' Privacy notice, in accordance with applicable law.
3. The Practice may use and /or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice had already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

Date Signed _____/_____ /_____ Witness: _____

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Thank you for choosing Health First Chiropractic. We appreciate your trust and confidence in us. Our Purpose is "To educate and adjust as many families as possible toward optimal health through natural chiropractic care." Our Mission is to change the health of our community one family at a time.

We are very serious about your health and that of your family. Subluxations (nerve interference) greatly decrease your body's health potential and rob you of your quality of life. We will ask you to be as dedicated as we are to allow chiropractic to be a major factor in your journey to health.

Insurance Coverage - We have been asked to join many of the HMO\PPO organizations in the area; we respectfully declined theses offers after finding out they drastically limit the quality of your care. To be able to offer you more affordable care, it is our policy not to bill health insurance companies. All our practice members pay us directly; we will provide you with a "super bill" for you to submit to your insurance company. It is a good idea to contact your insurance company and find out what your policy coverage is before you begin care. If your insurance company requires more documentation than a "super bill", there is a separate service fee for each visit. Payment in full is always appreciated; however, affordable payment plans are always available for those who need them.

If you have not attended our "New Patient Orientation" please do so. This class provides you with information about all the services offered at our office. The purpose of the orientation is to answer questions about your health, to explain how your body heals and to share with you the knowledge that will allow you to receive the most from your chiropractic care. The orientation is also great opportunity for your friends and family to ask questions and better understand the benefits of corrective chiropractic care. Patients who truly understand how and why chiropractic works always get better results.

God has blessed us with Chiropractic. It is our privilege to share this with you. Please relax and enjoy as you learn how chiropractic can change your life.

I have read and understand the above office policy.

Patient Signature:_____ Date:_____

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This Document Constitutes Informed Consent for Chiropractic Examination and Care

When a patient seeks straight chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Straight chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The Vertebral subluxation is the misalignment of spinal bones causing interference to the mental impulses traveling over the nerve pathways. The objective of straight chiropractic is to analyze the spine and locate and correct these vertebral subluxations. The straight chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE, is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize the doctor to perform a chiropractic examination to determine the presence of vertebral subluxation.

I hereby authorize the taking of x-ray films if necessary. I further agree that the above-mentioned doctor shall be the custodian of these x-rays.

All questions regarding the doctor's objective pertaining to detection of vertebral subluxation have been answered to my complete satisfaction.

I, _____ have read and fully understand the above statement.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I_____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination and adjustment if necessary.

_____ _____
(SIGNATURE) (DATE)