BARNESVILLE CHIROPRACTIC

Infant Patient Intake Form

Date:_____

Child's First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Sex: ☐Male ☐Female

Birth Weight: _____ Birth Length: _____ Primary Care Provider: _____

Name of Parent(s) or Guardian: _____

Phone _____ ☐ Cell ☐ Home

Emergency Contact Name:_____

Phone _____ Relationship _____

How did you hear about Barnesville Chiropractic?_____

Health Concerns

What are your primary concern(s)? _____

_____

When did the symptom(s) begin? _____

Has the child experienced this before? ☐ Yes ☐ No if yes, when? _____

What makes the child's symptoms worse? _____

_____

What makes the child's symptoms better? _____

_____

Many conditions chiropractors see are influenced by stressors. The following information helps us better understand your child's health history.

Pregnancy & Birth History

During Pregnancy, did the mother:

Smoke ☐ Yes ☐ No | Drink Alcohol ☐ Yes ☐ No

Take supplements/Vitamins ☐ Yes ☐ No | Receive Ultrasounds ☐ Yes ☐ No

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Hospital/Birthing Center: ☐ Home ☐ Hospital ☐ Birth Center

Length of pregnancy (weeks) _____ Was birth assisted? ☐ Yes ☐ No

If yes, how? ☐ C-Section ☐ Induced Labor

Were there any complications? ☐ Yes ☐ No - If yes, what were the complications? _____

_____

Any falls/accidents during pregnancy? ☐ Yes ☐ No

Infant Feeding History

Was/is the child breastfed? ☐ Yes ☐ No if yes, how long?
_____

At what age were the fallowing introduced?

Formula _____ Milk _____ Solid Foods _____

Has the child had any major falls or accidents since birth? ☐ Yes ☐ No

Any hospitalizations since birth? ☐ Yes ☐ No if yes, why _____

_____

Has the child received vaccinations? ☐ Yes ☐ No if yes, what _____

_____ Did the child have a reaction? ☐ Yes ☐ No

Has the child had antibiotics? ☐ Yes ☐ No If yes, how many times and for what reason? __

_____

Health & Development

Developmental milestones (age):

Rolling _____ Crawling _____ Walking _____ First words _____

Any concerns about the child's sleep? ☐ Yes ☐ No - If yes, what? _____

_____

Digestive concerns?
☐ None ☐ Constipation ☐ Reflux ☐ Colic ☐ Stomach aches

Are there any behavioral concerns? ☐ Yes ☐ No - If yes, what? _____

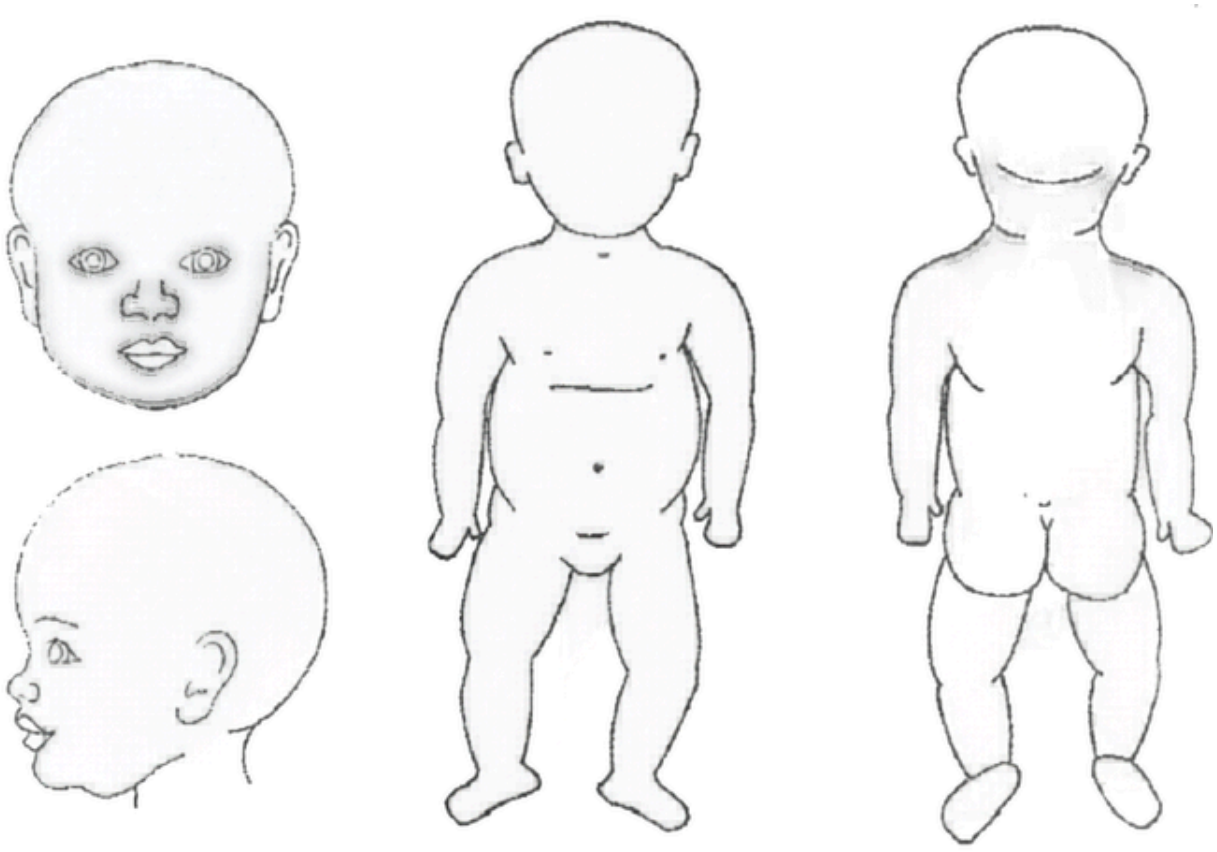
_____

Does the child have any behavior problems? ☐ Yes ☐ No if yes, explain _____

_____

Does the child participate in any sports or physical activities? ☐ Yes ☐ No if yes, what sport(s)_____

Please mark areas of concern



Cash Payment Policy

All patients please note: **The responsibility of payment rests directly with the patient.**

Cash patients must pay in full at the time of service. Barnesville Chiropractic accepts cash, check, and VISA/MASTERCARD/DISCOVER/DEBIT. Patients paying by check with insufficient funds will be charged an additional $25 along with original cost of treatment rendered.

PERSONAL INJURY (Automobile accidents and non-personal injury): Patient is responsible to inform Jewett Lake Enterprises of any/all personal injuries with open claims through an auto insurance company.

I HAVE READ AND UNDERSTAND THE BARNESVILLE CHIROPRACTIC CASH PAYMENT POLICY AND AGREE TO THE ABOVE TERMS.

Patient's Signature: _____

Authorization and Assignment

I authorize Barnesville 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 insured by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurer company obligated to make payment to me or you based on whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe.

I undersigned do hereby appoint Barnesville Chiropractic authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney fees or court costs required to collect my bill.

Patient Signature _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐YES ☐NO

If YES, please name the members allowed:

_____ _____

_____ _____

Patient's Signature: _____

Informed Consent

I hereby authorize physicians and staff at Barnesville Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed 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 at Barnesville Chiropractic responsible for any errors or omissions that I may have made at completion of this form.

Chiropractic, as well as all other types of healthcare, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risk prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about potential risks related to your care to allow you to be fully informed before consenting treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care system, we cannot promise a cure for any symptoms, conditions 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.

Specific Risk Possibilities associated with Chiropractic care: Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for case considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if occurs, you should report it to your doctor or staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care, while these are rare, they should be reported to your doctor promptly. Please understand Barnesville Chiropractic has private rooms for treatments.

If you have any questions concerning this form or above statements, please ask your doctor.

Having carefully read above, I hereby give informed consent to have chiropractic treatment administered.

Parent/Legal Guardian Signature: _____

Examination Form

Patient _____ DOB _____ Date _____

History: Past Chiropractic Care:

1.
2.
3.

Chief Complaints of Re-exam: (Worst to Least) Mark Left – Right – Bilateral

1. _____
2. _____
3. _____
4. _____
5. _____

Since last chiropractic appointment, any new referrals or diagnostic exams.

□X-ray □MRI □CT Scan □Urgent Care □ER □MD □Other _____

Who and when? _____ Results _____

Range of Motion

Cervical ROM % reduced: Flexion _____ Ext _____ LLF _____ RLF _____ LR _____ RR _____

Thoracic ROM % reduced: Flexion _____ Ext _____ LLF _____ RLF _____ LR _____ RR _____

Lumbar ROM % reduced: Flexion _____ Ext _____ LLF _____ RLF _____ LR _____ RR _____ _____ ROM % reduced: Flexion _____ Ext _____ LLF _____ RLF _____ LR _____ RR _____

Tenderness: **Cervical** R L B **CT** R L B **Thoracic** R L B **Lumbar** R L B **Shoulder** R L B **Leg** R L B

Other Tenderness: _____

Cervical Ortho: Spurlings + / - R L B **MAX** + / - R L B **Shoulder dep** + / - R L B **Distrac** + / - R L B

Lumbar Ortho: SLR + / - R ___ L ___ B ___ **Yeoman** + / - R L B **Kemps** + / - R L B **Nachlas** + / - R L B **Hibb's** + / - R L B **Ely's** + / - R L B **Faber** + / - R L B

Shoulder Ortho: Lift Off + / - R L B **Codman's** + / - R L B **Apley's** + / - R L B **Hawkin's** + / - R L B Other Ortho: _____

MSR * Reduced Positive: _____