PEDIATRIC PATIENT APPLICATION FORM

WELCOME TO 330 CHIROPRACTIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other chiropractic programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

____
Patient Signature:

____
Today’s Date:

____
File #:

Date: ________________

CHILD APPLICATION SURVEY

Name: ________________ Age: _______ Date: ________________

Preferred name/nickname: ________________ Gender: ☐ Male ☐ Female

Birth date: _____ /_____/_____

Home Address: ________________ Home Phone:________________

City, State, Zip: ________________

Parent Names: Father: ________________ Cell Phone:________________

Mother: ________________ Cell Phone:________________

Father e-mail address: ________________

Mother e-mail address: ________________

How were you referred to our office? ________________

PURPOSE OF THIS VISIT

Main Complaint: ________________

When did this begin? _____ / _____ / _____ Did it begin: ☐ Gradual ☐ Sudden ☐ Progressive over time

Have they experienced this condition before? ☐ Yes ☐ No If so, when? ________________

Who have you seen for this? ________________ What did they do? ________________

Last visit to your chiropractor? ________________ Results: ☐ Positive ☐ Negative ☐ Neutral

Overall Health Assessment

Pregnancy:

Birth Process: ☐ Natural ☐ C-Section ☐ Forceps ☐ Suction

☐ Mid-wife / ☐ Hospital Any problems during delivery? ☐ Yes ☐ No: ________________

Any trauma or concerns at birth? ________________

Growth and Development:

Formula: ________________ for ____ months Breast fed: _____ months

Difficulty in: ☐ Crawling ☐ Walking ☐ Running ☐ Climbing ☐ Sitting ☐ Standing

Check all that apply:

☐ Allergies	☐ Acid Reflux	☐ Asthma	☐ Back aches
☐ Bed wetting	☐ Behavior	☐ Broken bones	☐ Colds
☐ Colic	☐ Constipation	☐ Diabetes	☐ Delayed speech
☐ Diarrhea	☐ Dizziness	☐ Ear infections	☐ Headaches
☐ Heart trouble	☐ Hyperactivity	☐ Hypertension	☐ Juvenile RA
☐ Joint problems	☐ Leg problems	☐ Migraines	☐ Neck pain
☐ Poor posture	☐ Poor appetite	☐ Sinus	☐ Thyroid
☐ TMJ	☐ Underweight	☐ Overweight	

Other: ________________

Goals

What are your immediate goals: ________________

On a scale from 1-10(10=most committed) How committed are you to correcting this problem: ______

Medications Currently taking:

1. ________________ Reason: ________________
2. ________________ Reason: ________________

Parent Name (print): ________________

Parent Signature: ________________ Date: ________________

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to 330 Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of 330 Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the Doctor of Chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

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, disk 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

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

Signature____ Date _______________

(If under age 18) Parent's signature

Consent to x-ray:
I hereby grant 330 Chiropractic, LLC permission to perform an x-ray evaluation if needed of _____________. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

______________________ ___________
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child
I, ________________ being the parent of legal guardian of _________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

______________________ ___________
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature____ Date_____________________
(If under age 18) Parent's signature