Live Well
CHIROPRACTIC, LLC

Welcome to Our Office!

Thank you for choosing our office for your chiropractic care. We are committed to providing you and your family with the highest quality of chiropractic care available. We will be working together toward helping you reach your health and wellness goals.

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies ❑ Broken Bones ❑ Digestive Issues (constipation/diarrhea) ❑ Hypertension ❑ Orthopedic Problems

❑ Anemia ❑ Chronic Ear Aches ❑ Jeuvenile Rheumatroid Arthritis ❑ Paralysis

❑ Arm Problems ❑ Colds/Flu ❑ Dizziness ❑ Poor Appetite

❑ Asthma ❑ Colic ❑ Fainting ❑ Joint Problems ❑ Ruptures/Hernias

❑ Back Aches ❑ Convulsions/Seizures ❑ Headaches ❑ Leg Problems ❑ Sinus Trouble

❑ Bed Wetting ❑ Delayed Speech ❑ Heart Trouble ❑ Neck Problems ❑ Tuberculosis

❑ Behavioral Problems ❑ Diabetes ❑ Hyperactivity ❑ Neuritis ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Live Well Chiropractic, LLC is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. HIPAA requires a chiropractic practice to make a good faith effort to obtain a signed acknowledgement form from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

I acknowledge that Live Well Chiropractic, LLC staff provided me with a copy of their Privacy Practices Notice to review. I understand that I have a right to receive a copy of this Privacy Practices Notice if I request it.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

_____ Parent
_____ Guardian
_____ Power of Attorney
_____ Other _____

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OFFICE FEE SCHEDULE AND FINANCIAL POLICY

Financial Policy: We are committed to providing you the best chiropractic care possible in a caring environment and have established our financial policies to achieve this goal. You will be expected to pay for your chiropractic care at the time services are rendered unless other arrangements are made ***in advance*****.** Other arrangements include our bi-weekly, monthly and prepay ***Spinal Corrective Phase Plans***. The details of these plans will be discussed with you and all your questions will be answered at the time of your **Report of Findings** (second scheduled visit).

Health Insurance Policy: If you have insurance that covers chiropractic, we will give you a copy of the necessary paperwork **upon request** so that you may submit a claim to your insurance provider for reimbursement. It is your responsibility to send this information to your insurance provider. Your insurance company will communicate with you about your reimbursement. Remember, your agreement with the insurance company is between you and them, not us and them.

FEE SCHEDULE	
New Patient Consultation and Exam (Does NOT include Adjustment)	$75
Office Visit	$45

Fees and pricing structures are subject to an increase at any time. You will be given 30-day notice prior to changes going into effect.

Payment Information

Name of person responsible for payment: _____ (print please).

I understand and agree that I am personally responsible for payment of all fees charged by this office for care. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered or any outstanding balance on equipment/supplements placed upon the account will be immediately due and payable.

Dated the _____day of _____, 20____

Signature (person responsible for payment)_____

Patient Signature (if different than person responsible for payment) _____

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INFORMED CONSENT DOCUMENT

Patient Name: _____

TO THE PATIENT: PLEASE READ THIS ENTIRE DOCUMENT PRIOR TO SIGNING IT. IT IS IMPORTANT THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT. PLEASE ASK QUESTIONS BEFORE YOU SIGN IF THERE IS ANYTHING THAT IS UNCLEAR.

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure when I treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and therapy, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Vital Signs
Range of motion testing	Orthopedic testing	Basic neurological testing
Muscle strength testing	Postural analysis testing	Exercises

The material risks inherent in a chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you feel you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research topic is inconclusive as to a specific incident of this complication occurring. IF there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

- Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to treatment of minor

I hereby request and authorize Live Well Chiropractic, LLC, to perform diagnostic tests and render chiropractic adjustments and other treatments to my: _____

(Child’s name and your relationship to child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor’s discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Live Well Chiropractic, LLC, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Date Patient’s Printed Name

_____ _____

Patient’s Signature Signature of Parent or Guardian (if minor)

_____ _____

Doctor’s Signature Date

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CONSENT FOR CHIROPRACTIC TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Erica Whitlock, D.C., and whomever she may designate as her assistant(s) to administer treatment as she so deems necessary to my child:

_____
First Name Last Name

I hereby authorize only the individuals listed (other than myself), to bring my child/pick my child up from Live Well Chiropractic, LLC, for the purpose of chiropractic treatment.

_____
Name Phone

_____
Name Phone

_____
Name Phone

I acknowledge that I am the parent or legal guardian and I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I have read this form and certify that I understand its contents.

_____

Name: _____ Date: _____
Mother/Father/Legal Guardian

Signature: _____
Mother/Father/Legal Guardian