key dynamics CHIROPRACTIC

For office use:
Height: _____
Weight: _____
Head/Chest Circ: _____
BPM: _____
BP: _____

DEMOGRAPHICS

Patient name _____ SSN _____
Last First MI
Mother's name _____ Father's name _____
Legal Guardian *(if different)*_____
I would prefer to be called _____ Date of Birth ____/____/____ Age _____ M☐ F☐
When was the last time you saw a Chiropractor?_____
Street Address _____
City _____ State _____ Zip Code _____
Cell Phone _____ Work Phone _____ Home Phone _____
Email _____
Who may we thank for your referral? _____
Primary Care Physician _____

Authorization for Examination of a Minor

I, _____, hereby authorize and consent to the chiropractic examination of my infant, child or adolescent.

Parent/Guardian Signature _____ Date _____

CHIROPRACTIC CARE

Has your child ever seen a chiropractor? Yes ☐ No ☐ Whom _____ Date _____
Is your child on any medications? Yes ☐ No ☐ Please list all _____
_____
Has your child had any surgeries? Yes ☐ No ☐ Please list all _____
_____
Please describe any hospital visits for your child _____
_____

QUESTIONS FOR THE CHILD'S MOTHER

Did you carry your child full term? Yes ☐ No ☐ Weeks Gestation:_____
Describe any complications with pregnancy/delivery and when they occurred _____
_____
Hours of Labor:_____ Hours of Pushing:_____ Birth Weight/Length:_____ APGAR Score:_____
Were forceps used? Yes ☐ No ☐ Was vacuum extraction used? Yes ☐ No ☐
Epidural? Yes ☐ No ☐ Did you breastfeed? Yes ☐ No ☐
C-Section? Yes ☐ No ☐ Vaccinations? On Schedule☐ Delayed☐ Not Vaccinated☐
Did you consume alcohol during your pregnancy? Yes ☐ No ☐
Did you smoke during your pregnancy? Yes ☐ No ☐
Did you take any medications during your pregnancy? Yes ☐ No ☐
Additional information regarding pregnancy and birth: _____
_____

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AS A BABY/TODDLER (BIRTH TO 4 YEARS), DID YOUR CHILD EXPERIENCE ANY OF THE FOLLOWING?

- ☐ Fall from a changing table
- ☐ Fall out of crib
- ☐ Involved in an auto accident
- ☐ Fall from playground equipment
- ☐ Frequent ear infections
- ☐ Tonsillitis
- ☐ Colic
- ☐ Other _____
- ☐ Frequent crying
- ☐ Frequent fever
- ☐ Frequent bouts of diarrhea
- ☐ Constipation
- ☐ Sleeping problems
- ☐ Frequent colds
- ☐ Difficulty gaining weight

Please explain any boxes checked above _____

_____

_____

AS A CHILD (5-12 YEARS), DID YOU CHILD EXPERIENCE ANY OF THE FOLLOWING?

- ☐ Fall from tree
- ☐ Fall from playground equipment
- ☐ Involved in an auto accident
- ☐ Sports injury/accident
- ☐ Stomach pains
- ☐ Scoliosis
- ☐ Other _____
- ☐ Bed wetting
- ☐ Hyperactivity
- ☐ Autism
- ☐ Asthma
- ☐ Allergies
- ☐ Leg/Knee pain

Please explain any boxes checked above _____

_____

_____

AS A CHILD OR AN ADOLESCENT, HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in the ears
- ☐ Asthma
- ☐ Hyperactivity
- ☐ Fatigue
- ☐ Numbness in arms/hands
- ☐ Arm/wrist pain
- ☐ Sleeping problems
- ☐ Allergies
- ☐ Stomach problems
- ☐ Weight gain/loss
- ☐ Growing pains
- ☐ Neck/back pain
- ☐ Shoulder pain
- ☐ Foot/ankle pain
- ☐ Knee pain
- ☐ Other _____

Please explain any boxes checked above _____

_____

_____

Family Hx : (for office use only)

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CONCERNS

What is your child's major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms: getting worse?☐ getting better?☐ staying the same?☐

What treatment have you already received for your condition?

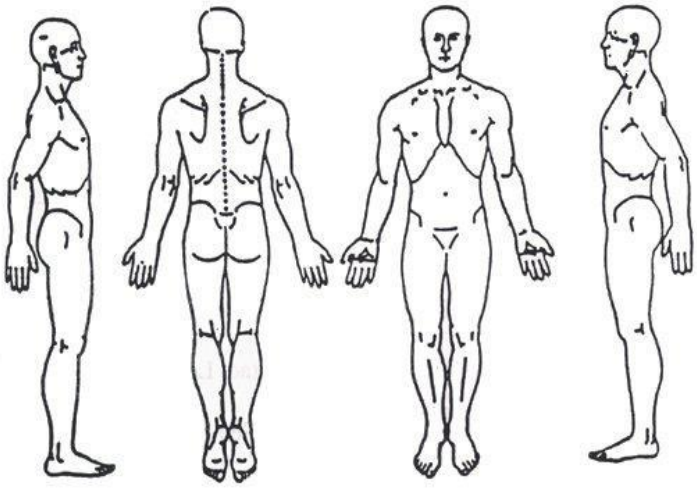
Medications☐ Physical Therapy☐ Chiropractic☐ None☐ Other: _____

Rate the Severity of your pain on a scale from 1 (least pain) to 10 (most pain): _____/10

Type of pain:

Sharp ☐	**D**ull ☐	**Th**robbing ☐	**A**ching ☐	**Sh**ooting ☐
Burning ☐	**N**umbness ☐	**T**ingling ☐	**St**iffness ☐	**O**ther ☐

Place appropriate highlighted letters to mark the areas of discomfort



How often does this pain occur? Constant (+75%)☐ Frequent (50-75%)☐ Occasional (25-50%)☐ Intermit(<25%)☐

Does it interfere with: Play☐ Sleep☐ Daily Routine☐ School☐

Activities or movements that are painful: Sitting☐ Standing☐ Walking☐ Bending☐ Lying Down☐

Other comments or concerns regarding this condition: _____

_____

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below that he/she is/are a licensed chiropractor, and though rare, injury resulting from manipulation may include sprain/strain, disc herniation, stroke, death and other injuries or complications.

I agree to hold Dr. Amanda Buchanan, any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatsoever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding on and insure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with the treating Doctor of Chiropractic, that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Guardian Signature _____ Date _____

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Financial and Insurance Disclaimer

Financial Policy

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, and/or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. In order to make this convenient, we accept most major credit cards, cash and personal checks. If, on occasion, it is not possible to pay in full, we are willing to establish a payment schedule with you. However, the balance may not exceed $250.00 and the full balance must be paid within 30 days. Personal balances over 30 days old may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility. A $20.00 fee will be applied to appointments not canceled within 12 hours of the scheduled appointment time. Appointments Monday must be canceled Friday before closing.

Insurance Policy

Our office works with insurance companies to accept your coverage. Our staff will call the insurance company to verify your coverage and will explain to you the information they obtain. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted us. NOTE: Verification is not a guarantee of benefits. We assume no responsibility for the information we receive from your insurance company, concerning how much or what your insurance company will pay for. The final financial responsibility is yours. Should you have questions at any time, do not hesitate to contact the staff or office manager.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dr. Amanda Buchanan will submit services rendered for my care for payment under the contract I have with my health and/or accident carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered to me and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any unpaid fee for professional services rendered to me will be immediately due and payable.

Guardian Signature _____ Date _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Guardian Signature _____ Date _____

CMS requires providers to report both race and ethnicity:

Race (Circle One): American Indian or Alaska Native/ Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer **Preferred Language:** Eng Spanish Other