Ages 5-17

Peak Family Chiropractic

132 Merz Blvd. Fairlawn, Ohio 44333
(330) 670-9400(p) ~ (330) 670-9401 (f)

Date: _____

Who may we thank for referring you to our office? _____

Patient Information

Name:_____ _____ _____ Date of Birth:_____ Age:_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____ Sex: _____

Home Phone:_____ Cell Phone:_____ Cell Phone Carrier:_____

Email:_____

Mother's Name: _____ Mother's Occupation:_____ Mother's Phone:_____

Father's Name:_____ Father's Occupation:_____ Father's Phone:_____

In Case Of Emergency, Contact:

Name:_____ Relationship:_____ Contact Number:_____

Health Insurance Information

Name of Insurance Company: _____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Name of Secondary Insurance:_____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Is your office visit due to an auto accident or work injury? ☐ Yes ☐ No If yes, which one applies? ☐ Auto accident ☐ Work Injury

Pregnancy, Birth History, and Development

Did you experience any complications with your pregnancy? (Check all that apply)

- ☐ Back/Other Pain
- ☐ Pre-Term
- ☐ Gestational Diabetes
- ☐ Fatigue
- ☐ Pre-Eclampsia
- ☐ Swelling
- ☐ Strep B
- ☐ Nausea/Vomiting

Other:_____

Type of Birth/Complications preceding birth: (check all that apply)

- ☐ Hospital
- ☐ Cesarean
- ☐ Birthing Center
- ☐ Scheduled/Induced
- ☐ Home
- ☐ Epidural
- ☐ Normal/Vaginal
- ☐ Breech
- ☐ Antibiotics
- ☐ Respiratory Distress
- ☐ Congenital Abnormalities
- ☐ Extended Hospitalization
- ☐ Failure to Thrive
- ☐ Jaundice
- ☐ Meconium

Infant Feeding: ☐ Breast ☐ Bottle ☐ Formula

Number of Hours of sleep each night:_____ Quality of Sleep:_____

Continue to page 2

Current Health Conditions

☐ Wellness Checkup? ☐Other:_____

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

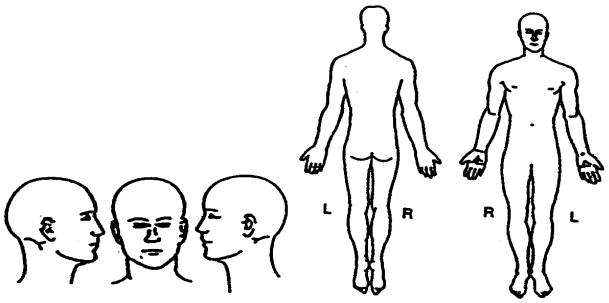
How long has it been a problem?_____ When is it worse?_____

Was there an injury or episode? (How did it start?) _____ Date:_____

How intense are your symptoms? (circle) **0 1 2 3 4 5 6 7 8 9 10**
No symptoms ***intense symptoms***

What does the pain feel like? (Check where appropriate)

- ☐ Numbness
- ☐ Dull
- ☐ Sharp
- ☐ Throbbing
- ☐ Tingling
- ☐ Aching
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Cramping
- ☐ Burning
- ☐ Swelling
- ☐ Other: _____



Circle location(s) of symptom on the body drawing

Does the pain radiate?_____ If so, Where to? _____

What makes your child's pain better?_____
(Examples: Over the counter medication, hot pack/cold pack, rest, exercise, sitting, standing, etc.)

What makes your child's pain worse?_____
(Examples: sitting, standing, exercise, computer work, walking, etc.)

What treatments has the child tried since suffering with this problem?_____
(Ice, Heat, Physical Therapy, Chiropractic, Massage, over the counter medication, prescription medication, etc.)

Please identify how your current condition effects your life. Place an "X" in the most appropriate box:

Condition	No Effect	Painful (Can Do)	Painful (Limits Activity)	Unable to Perform at all
Sit to stand				
Climbing Stairs				
Pet Care				
Extended Computer Use				
Household Chores				
Reading/Concentration				
Bathing				
Dressing				
Sleep				
Static Standing				
Static Sitting				
Walking				
Sports/Recreational Activities				
Other:				

Continue to page 3

Social and Health History

Please check all of the items that apply to your child now and in the past:

- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Rubeola
- ☐ Pertussis/Whooping
- ☐ Allergies
- ☐ Anemia
- ☐ Arm Problems
- ☐ Asthma
- ☐ Back Aches
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ Broken Bones
- ☐ Chronic Ear Aches
- ☐ Cold/Flu
- ☐ Colic
- ☐ Convulsions/Seizures
- ☐ Delayed Speech
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Dizziness
- ☐ Headaches
- ☐ Heart Trouble
- ☐ Hyperactivity
- ☐ Hypertension
- ☐ Juvenile Arthritis
- ☐ Joint Problems
- ☐ Leg Problems
- ☐ Neck Problems
- ☐ Neuritis
- ☐ Orthopedic Problems
- ☐ Paralysis
- ☐ Poor Appetite
- ☐ Ruptures/Hernias
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Walking Problems

Have you vaccinated your child? Yes____ No____ As Scheduled____ Delayed Schedule____ Comments:_____

Has your child ever seen a Chiropractor? Yes_____ No_____ If yes, Name of Chiropractor _____

Primary Care Physician: _____ Phone Number: _____

Please list all of the medications *with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)* that you are currently taking. Include over-the-counter, prescriptions, herbals, and vitamins/minerals:

Drug Name: _____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____
_____
_____
_____

Surgeries: _____ year_____
_____ year_____
_____ year_____
_____ year_____
_____ year_____

Family History:
Please list any conditions affecting your child's immediate family.

Mother:_____
Father:_____
Brothers:_____
Sisters:_____

Physician Notes:
_____
_____
_____
_____
_____
_____
_____
_____

Continue to page 4

Consent to Treat

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:_____

Continue to page 5

HIPPA Acknowledgement

I acknowledge that I have reviewed/received a copy of Peak Family Chiropractic Notice of Privacy Practices.

_____
Name of Patient (Please Print)

_____ _____
Signature of Guardian Date

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

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other:_____

Please note: It is your right to refuse to sign this Acknowledgement

Office Use Only

I tried to obtain written acknowledgement by the individual noted above of the receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgment.
__ The individual was unwilling to sign
__ Other: _____

_____ _____
Staff Member Signature Date

Financial Policy

Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. If you prefer we can set up payments on an EFT (electronic fund transfer) from your account. We are happy to accept your check, Master Card, Discover or Visa card.

GROUP OR INDIVIDUAL INSURANCE

After your first visit, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance are not a guarantee of payment. Credit Guarantee form must be filled out and signed. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Workman's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees for services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. Our office completes and files the forms for Medicare at no cost.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help filing.

I have read and understand the payment policy of Peak Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Peak Family Chiropractic and my insurance company. I request that Peak Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.

Guardian Signature Date_____