Confidential Patient Information

Child's Legal Name:		**DOB (MM/DD/YY):**	
Parent/Guardian Name:		**Gender:**	**Age:**
Phone Number:		**Weight:**	**Height:**
Address:	**City:**	**State:**	**Zip:**

Child's Current Health Concerns

What health concerns bring your child to the chiropractor?

Has she/he had this problem before? If so, how was it treated?

Which of the following describes their symptoms?	How is the health concern NOW?
◯ They have been experiencing these symtpoms for a long time	◯ Rapidly improving
◯ They just recently started experiencing these symptoms.	◯ Slowly improving
◯ There are no symptoms, we are seeking wellness care.	◯ About the same
◯ Other	◯ Gradually worsening
	◯ Rapidly Worsening

Please select all of the following your child currently has or has had in the past:

☐ Dizziness	☐ Bed Wetting	☐ Asthma	☐ Arm Pain
☐ Headaches	☐ Constipation/Diarrhea	☐ Colic	☐ Bladder Problems
☐ Sinus Issues	☐ Back Aches	☐ Gas/Bloating	☐ Behavioral Issues
☐ ADD/ADHD	☐ Growing Pains	☐ Sleeping Difficulties	☐ Nervousness/Anxiety
☐ Ear Infections	☐ Breathing Difficulties	☐ Leg Pain	☐ Frequent Illness (cold/flu)

Child's Growth & Development

Breastfeeding	Formula
Was your child breastfed? ◯ Yes ◯ No	Did they ever use formula? ◯ Yes ◯ No
For how long?	For how long?
Were there any feeding difficulties? ◯ Yes ◯ No	What kind?

Does he/she have food sensitives? ◯ Yes ◯ No

Is/were there any milestone delays? ◯ Yes ◯ No

Has your child ever received antibiotics? ◯ Yes ◯ No

If so, about how many times & for what infection?

Have you chosen to vaccinate your child? No

Have there been vaccine reactions? ◯ Yes ◯ No

Child's Past Health Concerns

List all previous surgeries & broken bones:

Previous Conditions & Traumas:

Condition	Never	Current	Past	Traumas
Spinal Surgery	○	○	○	☐ Fall (changing table, bed, bike, etc
Cancer	○	○	○	☐ Sports Injury
Rapid Weight Gain/Loss	○	○	○	☐ Concussion
Difficulty Breathing	○	○	○	☐ Four Wheeler/Dirt Bike Accident
Seizures/Epilepsy	○	○	○	☐ Car Accident

Mother's Pregnancy & Birthing Process

Were there fertility struggles prior to conception? ○ Yes ○ No
Did mother smoke? ○ Yes ○ No
Did mother drink? ○ Yes ○ No
Did mother exercise? ○ Yes ○ No
Was mother frequently ill? ○ Yes ○ No
Was mother under physical or mental stress? ○ Yes ○ No
Which of the following best describes your birthing process?

Family History

Family	Diabetes	Cancer	Heart Disease	Stroke	Arthritis	ADHD	Kidney Disease
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐	☐	☐

Child's Social History

List all current medications:

List all known allergies:

Our goal is to expand financial access to chiropractic care so you can receive the care you need. As part of our commitment to your health care needs, we offer Interest Free Payment Plans to meet your budget. At Eden Family Chiropractic, we don't want you to suffer because of financial issues. That is why we are pleased to offer premier payment programs to meet your budget. Our plans are created in-house for maximum convenience without a 3rd party hassle. We accept all major credit cards & Care Credit.

I have provided accurate and complete information to the best of my knowledge.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**

Acceptance & Consent

Terms of Acceptance

In order to provide the most effective chiropractic care, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is **not** the practice of medicine.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a **safe, effective** procedure applied over one million times each day doctors of chiropractic in the United States alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
5. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with any recommendations is essential to maximum healing and optimal health though chiropractic.
7. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis. By my signature below, I have read and fully understand the above statements.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**

Written Consent For Children

-I authorize Dr. Danielle Wright and any & all qualified Eden Family Chiropractic staff to perform diagnostic procedures and radiographic evaluations to my minor/child if deemed necessary. I hereby authorize Dr. Danielle Wright to render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize health care is revoked or altered, I will immediately notify Eden Family Chiropractic.

By typing your name below, you are agreeing to the above statements.

Signature of Guardian	**Today's Date**

Informed Consent for Chiropractic Care

-Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondarily to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

-Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and your spinal health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

-I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as
reported following my assessment.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**

Necessary X-Ray Authorization

-As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain your x-rays in our files. We can provide you with a copy of your x-rays. The fee for copying your x-rays is $10.00 & collected in advance. Digital x-rays on CD will be available within 24 hours of prepayment during regular adjusting hours on days of business.

-Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Eden Family Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

-Females Only: To the best of my knowledge, I am not pregnant at the time x-rays are to be taken at Eden Family Chiropractic.

-By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

-After careful consideration, I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**

Notice of Privacy Practices Acknowledgement

-I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

-I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**

Appointment Reminders

By signing below, I authorize Eden Family Chiropractic and its affiliates to contact me by automated SMS text message for appointment reminders.

By typing your name below, you are agreeing to the above statements.

Signature	**Today's Date**