Child's Case History

Please Print

Patient Information

Child's Name ____ Date of birth ___________________

Mother's Name _________________________________ Father's Name _____________________________

Address ________________________________ City ____________________ State ______ Zip ________

Home Phone ___________________________ Cell phone ____

Mother's History

Tell me about your prenatal time:

Did you exercise? ___Y ___N please explain ____

Did you drink alcohol? ___Y ___N please explain ____

Did you take drugs? ___Y ___N please explain ____

Did you eat regularly? ___Y ___N please explain ____

Did you have any spinal pain or problems during you pregnancy? ___Y ___N please explain

____

Labor

How long was labor? ____

Was labor artificially induced? ___Y ___N

Would you say it was ___ Easy ___ Hard ___ very Hard

Did you have a spinal block / Epidural? ___Y ___N

How did you deliver the child? ___ on back ___ On all fours ___ Squatting ___ Sitting up in birthing chair ___other

Did the doctor grasp/pull on the child's head? ___Y ___N

Did you notice if the doctor twisted? ___Y ___N

Were forceps used? ___Y ___N

Do you remember the APGAR score? ___Y ___N If so, what was it? ____________________________________

Any complications? ____

Baby's History

Was this child breastfed? ___Y ___N How long? ____

Did this child have any unusual or strange habits or behaviors as a newborn?

____

Child's Case History (cont.)

Please Print

Colic? ___Y ___ N

Fussy? ___Y ___N Alert? ___Y ___N Happy? ___Y ___N

Did child have shots (immunizations)? ___Y ___N

Did child crawl? ___Y ___N Beginning at what age? ___months

Was child in a walker? ___Y ___N How long? _________________

For how long did the child crawl? ____________________________

At what age did child begin to walk? __________________________

Did you notice anything unusual about the child's efforts to learn to walk? ___Y ___N

Did the child fall a lot? ___Y ___N

Were there any particularly hard falls that you recall? ___Y ___N

If so, please explain: ____

Young Child

Ear infections? ___Y ___N

Colds? ___Y ___ N

Mucus/Sinus trouble? ___Y ___ N

Falls? ___Y ___N

Collisions (Automobile)? ___ Y ___N

Anything else you have noticed about your child that you think is unusual:

____

____

List any medications, past or present:

____

____

Any diagnosed diseases:

____

____

Signature of Mother, Father, or Legal Guardian ____ Date ______________

Patient Symptoms Questionnaire

Please Print

Patient Name: ____ Date: __________________________

Symptoms

1. What is your number-one problem or the one area of greatest pain? ____

____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt.

If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

3. When did this problem/pain start? _____________________________ ____ Gradual ____ Sudden ____ Progressive

4. What do you think caused this problem? ____

5. How often do you experience the pain?

____ 1-2 hours per day ____ About half of the day _____ Most of the day ____ The pain never goes away

6. How does the pain affect your daily activities?

____ It does not affect my daily activities ____ I have had to change how I do things

____ I have had to stop doing some of my daily activities ____ I am unable to perform daily activities

7. What increases your pain? ____

8. What decreases your pain? ____

9. Have you ever experienced this problem before? **Y N** When? ____

10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

a. ____ 0 1 2 3 4 5 6 7 8 9 10
b. ____ 0 1 2 3 4 5 6 7 8 9 10
c. ____ 0 1 2 3 4 5 6 7 8 9 10
d. ____ 0 1 2 3 4 5 6 7 8 9 10

If you have experienced any of the following conditions in the **past** mark a **"P"** on the line provided. If you are **currently experiencing** any of the following conditions please mark a **"C"** on the line provided. (check all that apply)

___ heart attack ___ stroke ___ arthritis ___ gall bladder trouble
___ diabetes ___ glaucoma ___ fainting spells ___ kidney stones
___ difficulty with urination ___ bloody stools ___ difficulty with bowel movements
___ prostate trouble ___ anemia ___ cancer ___ asthma
___ AIDS ___ ulcers ___ diverticulosis ___ menstrual cramping
___ dizziness ___ loss of memory ___chest pain ___ shortness of breath
___constipation ___ diarrhea ___ general fatigue ___ sudden weight loss
___ nausea ___ muscle cramping ___ soreness in joints ___ loss of hearing
___ ears ringing ___ headache ___ migraine ___ epilepsy
___ gout ___ tuberculosis ___ syphilis ___ sprained ankle R L
___ knee/hip replacement ___ broken bones (specify) ____________________________

Patient Symptoms Questionnaire (cont.)

Please Print

Patient Name: ____ Date: _________________________

General Activities (check all that apply)

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ use two or more pillows to sleep with
___ needlepoint/knitting ___ sewing
___ lift weights/wt. mach. ___ play video games (___ hrs per day)
___ exercise ____x/wk ___ jog ___ x/wk ___ computer use (___ hrs per day)
___ swim ___ use elliptical ___ watch television (___ hrs per day)

Please add anything else you would like the doctor to know:
____
____
____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature ____ Date ___________________
(signature of parent if the patient is a minor)

*Doctor's comments:*____
____
____
____
____
____

B•STRONG4LIFE™

Kingen chiropractic wellness center
healthy body, healthy mind, healthy solution

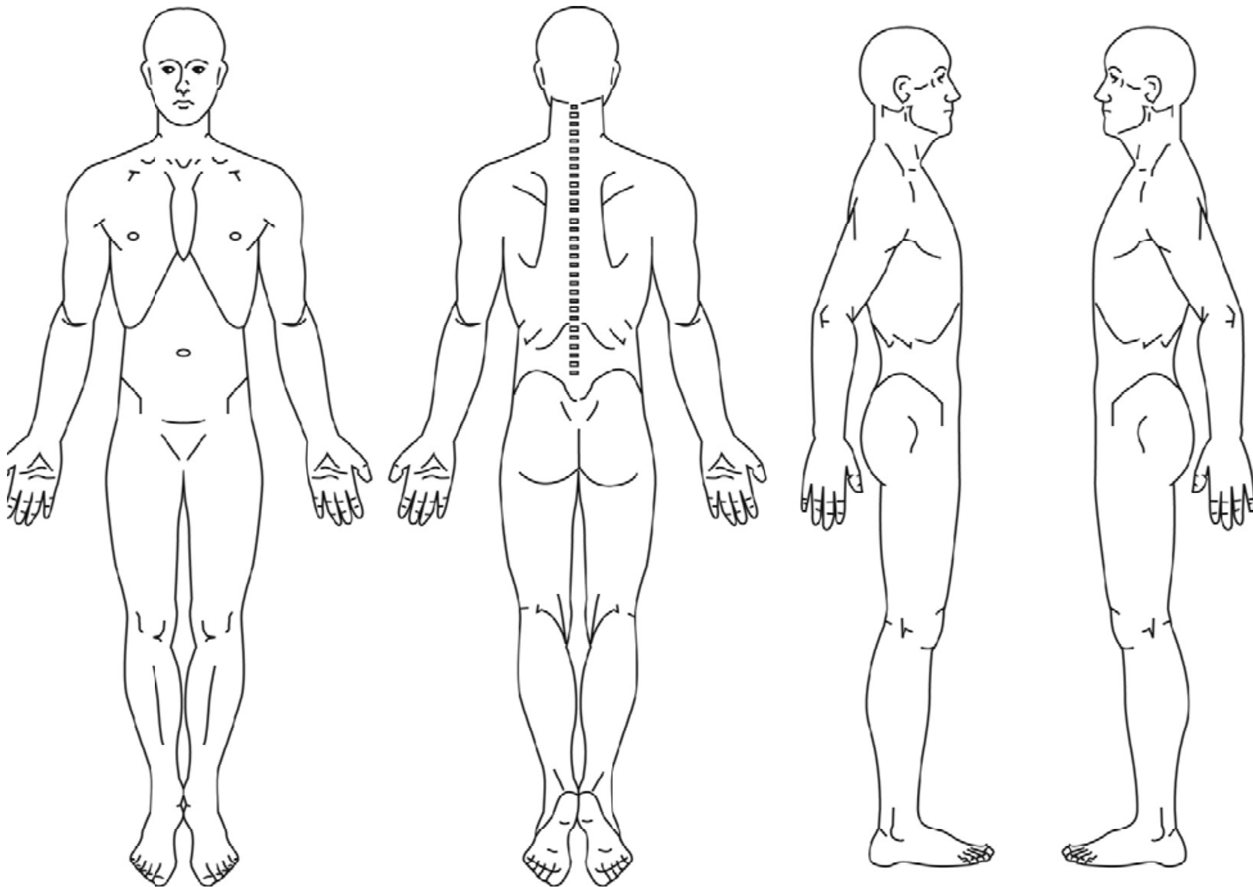
Pain Diagram

Please Print

Patient Name: ____ Date: __________________________

Please complete the following "Pain Diagram" by using the letters below to indicate on the diagram your areas of pain:

(P) Pain **(T) Tingling** **(N) Numbness** **(B) Burning** **(S) Stiffness**



Notes:

____

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Financial Policy

It is the goal of this office to provide you the FINEST QUALITY CHIROPRACTIC CARE available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

- I hereby acknowledge and understand that **all** charges incurred at Kingen Chiropractic Wellness Center are my responsibility.
- Kingen Chiropractic Wellness Center reserves the right to apply a service charge on all delinquent amounts more than 90 days past due. This fee will be computed at a rate of 1 1/2 % per month, 18% annum. This includes all personal injury and/or worker's compensation cases not settled within 90 days after the case is closed.
- In the event it becomes necessary for Kingen Chiropractic Wellness Center or it's agents to employ legal and/or collection counsel, I understand and agree I am responsible for payment of all collections and attorney's fees, which will be added to my account/bill.
- All returned checks will be charged a twenty-five dollar service fee, plus any additional fees (i.e. bank fees, collection fees, etc…).
- There will also be a missed appointment fee of $15.00.

I have read and understand everything described in the Financial Policy, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____________________________	____________________________
Name of Individual (Printed)	Signature of Individual
____________________________	____________________________
Signature of Legal Representative	Relationship
____________________________	____________________________
Witness	Date Signed

Patient Acknowledgement
For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

___________________________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out it's healthcare operations. The practice has further explained my right to obtain a copy of this Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The practice's "Notice of Privacy Practices:" is also provided **in the patient bookcase** and on the practice's web site at www.kingenchiropractic.com I may also request a copy from this office at any time via USPS, but will be personally responsible for copy fees and any postage due.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected healthcare information.

I have read and understand everything described in the Patient Acknowledgement (PHI), and all of my questions have been answered to my full satisfaction in a way that I can understand.

____________________________	____________________________
Name of Individual (Printed)	Signature of Individual
____________________________	____________________________
Signature of Legal Representative	Relationship
____________________________	____________________________
Witness	Date Signed

TERMS OF ACCEPTANCE
Kingen Chiropractic Wellness Center

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. 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 of correction 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 its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the 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. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I,_____________________________have read and fully understand the above statements.
(*print name*)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____________________________________ ________________________________
(*name*) (*date*)

Consent to evaluate and adjust a minor child

I,____________________________________being the parent or legal guardian of ______________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_________________________

_______________________________________ ____________________________
(*signature*) (*date*)