

Welcome to The Human Joint

We promise to take very good care of your child!



Think of Wellness First as a group practice. Our promise to you is this: All of the doctors who work in this office will share the same philosophy of wellness, use the same adjustive techniques, and keep records that can be read and understood by each other. If, on occasion, the doctor your child is scheduled with is unavailable, another completely qualified doctor may fill in without prior notification.

Please fill out this patient questionnaire as completely and accurately as possible. Here is our promise to you: This is an extensive written history because the more information that we have about your child, her past and current health concerns, your family history, and the family's lifestyle the more effective we will be in helping your child along her path to better health.

We promise that our consultation will be thorough, and that we will endeavor to learn as much as possible about your and your concerns. Ours is a Whole-Body, Whole-Mind, Whole-Spirit approach to wellness. We may ask questions which seem at first to be far removed from your child's area of concern. However, rest assured that our eyes, ears, and hands are always searching for answers to your specific questions and concerns. You help us most when you are open, honest, and complete.

Our treatment recommendations will be made according to our consultation and examination findings, as well as how your child responds to their early adjustments. We promise: NO "COOKBOOK" RECOMMENDATIONS. Our suggestions regarding frequency of visits, "home work," and lifestyle changes will be as individual as your child is. Changes in the treatment schedule should ideally follow your child's improvement rather than outside influences such as hectic schedules or financial constraints. It is our hope that together we can arrive at a treatment schedule with is realistic in both time and financial investment for you and you child.

There are several levels of care available at Wellness First: Please give some thought to where you would place your child on this list. We welcome you and your child at whatever level you choose.

Relief Care Only: Your child has very obvious symptoms which are disrupting your family. You choose to bring him in only when his symptoms are obvious and disruptive, you stop bringing him in when symptomatic relief is attained, and you will only bring him in for care again when symptoms become obvious and disruptive again.

Relief Care with an openness to Corrective Care and/or Wellness Care: Your child has very obvious symptoms which are disrupting your family, and you have an immediate goal of relief. However, you also understand that many future flare-ups may be avoided and your child's overall health can be improved with proper care. You are interested in maintenance or wellness care for you child once this particular acute episode is corrected and resolved.

Corrective Care: Your child has some level of ongoing, mild to moderate, chronic symptoms which are the result of birth trauma, a fall, or other unfortunate circumstances. You bring her here to receive ongoing corrective care. You know that her body functions more normally after each chiropractic adjustment than it did before the adjustment, and that her existing health concerns will go on to become more and more symptomatic unless you make a commitment to her better health, which will include regular "tune up" adjustments and possibly some lifestyle changes for the family.

Wellness Care: At this level, your child is rarely in any discomfort and his symptoms are minimal. You bring him here to receive wellness care in order to ensure that his body keeps functioning optimally and so that he may continue to feel his best. You understand that his level of symptoms, (or lack thereof), is not necessarily an accurate gauge of how healthy they are ~ that imbalances of his structure can exist with few symptoms while silently compromising his overall health.

The Human Joint
40 West Louisiana Avenue Denver, Colorado 80223
303.744.6567 phone 303.733.6567 fax
www.thehumanjoint.com

Child's Name: _____ Today's Date: _____

Address: _____

 Telephone #s: (hm) _____
 (wk) _____
 (mom's cell) _____
 (dad's cell) _____
 (fax) _____
 Family email address: _____
 Mom's Name: _____
 Mom's Employer: _____
 Dad's Name: _____
 Dad's Employer: _____

Date of Birth: _____
 Gender: M F
 Child's Status:
 Infant Baby Toddler Teenager
 FT Employed _____
 PT Employed _____
 FT Student _____
 PT Student _____
 Child's Relationship to the Insured:
 Self Spouse
 Child Other
 What is the cause of the child's symptoms?
 Employment? Y N
 A vehicle crash? Y N
 What state? _____
 Home accident? Y N
 Other accident? Y N
 Illness? Y N
 Unknown? Y N

How did you hear about our office? _____

Does your child have any previous chiropractic experience? Y N If so, please tell us if you were satisfied with their care Y N , and when (approximately) was their most recent adjustment _____?

Does your child see a primary care physician or medical specialist regularly? Y N If so, please list their names and specialties, and the approximate date of the last visit. _____

How many prescription and over the counter medicines is your child currently taking? _____ Who is monitoring their use of these medicines? _____

Please list any condition that the doctor here should be aware of: _____

Has your child ever been treated on an emergency basis anywhere, for any reason? Y N Please explain: _____

Please list all surgeries your child has had: _____

Are there any other health issues are you interested in exploring with the doctor here? Please circle all that apply.
VACCINATIONS NUTRITION DIETARY SUPPLEMENTS IMPROVED IMMUNITY INFERTILITY LIFESTYLE ALLERGIES
ADD/ADHD OTHER _____

Child's Name: _____ Today's Date: _____

****Please fill out this page for children 10 and under only****

Any problems or complications during pregnancy? _____

Name & credentials of birth professional(s): _____

Location of birth: _____

Type of delivery (please circle all that apply): VAGINAL FORCEPS BREECH CESAREAN MULTIPLE EMERGENCY
OTHER _____

Any problems or complications during labor and delivery? _____

APGAR scores: _____/_____ Presence of Jaundice? Y N Presence of Cyanosis? Y N

Birth Weight ___lbs. ___oz. Current Weight ___lbs. ___oz.

Birth Length _____" Current Length _____"

of siblings _____ Birth Order _____

Congenital anomalies/defects known: _____

Vaccinations (circle all that apply):
NONE.....I DON'T INTEND TO HAVE MY CHILD VACCINATED
NONE SO FARI AM UNDECIDED ABOUT THIS ISSUE
PARTIAL.....MY RESEARCH LEAD ME TO LEAVE OUT SOME OF THE VACCINES
PARTIAL.....I JUST HAVEN'T HAD A CHANCE TO CATCH UP YET
COMPLETEUP TO DATE ON ALL RECOMMENDED VACCINES
I WOULD LIKE MORE INFORMATION ABOUT THIS ISSUE.

My child has had the following diseases: _____ At what age? _____

- Chicken Pox _____
- Rubeola _____
- Rubella _____
- Measles _____
- Scarlet Fever _____
- Mumps _____
- Whooping Cough _____
- Otitis Media _____
- Other _____

Any other conditions that the doctor should know about? _____

At what age did your child first:

respond to sound _____	creep _____
track with eyes _____	crawl _____
hold head up _____	pull up _____
sit up alone _____	stand alone _____
roll over _____	walk alone _____
complete potty training _____	

What is the purpose of this visit? _____

Child's Name: _____ Today's Date: _____

The Doctor-Patient Relationship

Informed Consent

Please discuss any questions that this agreement brings up with a doctor before signing.

Chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate healing powers and heal itself.

A Doctor of Chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). Chiropractic adjustments and ancillary procedures may be administered in an attempt to restore spinal integrity. Due to the complexities of the human body and nature, no doctor can promise specific results. You should be mindful of your child's symptoms and you should seek other opinions if you have any concerns as to the nature of his or her total condition. You are always responsible for the decisions which concern your child's health.

In coming to this office and signing this form, you have granted all of the Doctors of Chiropractic at Wellness First, and any qualified visiting Doctor of Chiropractic, permission and authority to examine and treat your minor child. You authorize the performance of chiropractic adjustments and other chiropractic procedures, as well as various modes of adjunctive therapy on you child. The chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. However, in rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The Doctor of Chiropractic will not render a chiropractic adjustment or other procedures if they are aware that such care may be contra-indicated. The doctors will not be responsible for any pre-existing medically diagnosed condition or for any medical diagnosis of which they have not been made aware. We also want you and you child to be comfortable. Therefore, if you would like the doctor to stop, for any reason, at any point during examination or treatment, please say so.

I have read, and I understand the above statement of Informed Consent.

Signed: _____

Date: _____

For minor child: _____

Financial Agreement

Please discuss any questions that this agreement brings up with a doctor before signing.

I agree that I am responsible for all expenses incurred by my child at Wellness First. If I have insurance, **I understand that the insurance benefits exist as part of a contract between me and my insurance company,** and that Wellness First may provide insurance billing or paperwork as a convenience to me. As a part of this service, Wellness First may call my insurance company to attempt to obtain information about policy terms and coverage for chiropractic care. I understand that, despite this service, it is possible that inaccurate information may be given by my insurance company regarding my policy terms and coverage for chiropractic care. If proper insurance verification procedures are followed, I will not hold Wellness First responsible for inaccurate information given by my insurance company.

With this signature, I hereby authorize payment by my insurance company directly to Wellness First all benefits which may otherwise be payable to me for services rendered. I authorize Wellness First to release any information required to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

I have read, and I understand the above Financial Agreement.

Signed: _____

Date: _____

For minor child: _____

The Human Joint
40 West Louisiana Avenue Denver, Colorado 80223
303.744.6567 phone 303.733.6567 fax
www.thehumanjoint.com