Name:_____ **Today's Date:**_____

Address:_____

_____

Telephone #s: (hm)_____

(mom's cell)_____

(dad's cell)_____

(fax)_____

Family e-mail address:_____

Mom's Name:_____

Mom's Employer:_____

Dad's Name:_____

Dad's Employer: _____

Date of Birth:_____

Age: _____

Gender: M F

_____

_____

What is the cause of your 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? _____

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

Do you 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 are you currently taking?_____ Who is monitoring your use of these medicines?_____

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

_____

Have you ever been treated on an emergency basis anywhere, for any reason? Y N Please explain:_____

_____

Please list all surgeries you have had:_____

_____

Are there any other health issues you or your parent/guardian are interested in exploring with the doctor here? Please circle all that apply.

VACCINATIONS NUTRITION DIETARY SUPPLEMENTS IMPROVED IMMUNITY INFERTILITY LIFESTYLE ALLERGIES ADD/ADHD OTHER_____

_____

Your Name:_____ **Today's Date:**_____

Have you had any accidents, traumas, or injuries?_____

Name & credentials of pediatrician:_____

# of siblings _____ Birth Order _____

Congenital anomalies/defects known:_____

Vaccinations (circle all that apply):
(Please have your parent/guardian answer this question.)

NONE……I DON'T INTEND TO HAVE MY CHILD VACCINATED
NONE SO FAR ……I 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
COMPLETE ……...UP TO DATE ON ALL RECOMMENDED VACCINES
I WOULD LIKE MORE INFORMATION ABOUT THIS ISSUE.

I have 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?_____

What is the purpose of this visit?_____

Your 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 The Human Joint, 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 your 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 your 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 The Human Joint. If I have insurance, ***I understand that the insurance benefits exist as part of a contract between me and my insurance company***, and that The Human Joint may provide insurance paperwork as a convenience to me. As a part of this service, The Human Joint 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 The Human Joint responsible for inaccurate information given by my insurance company.

With this signature, I hereby commit to pay for all services at the time they are rendered.

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

Signed:_____ **Date:**_____

For minor child:_____