PATIENT (CHILD) INFORMATION

DATE: _____ ACCOUNT# _____

First Name _____ Initial _____ Last _____ Called _____

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Father's Name _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

DOB _____ Social Security# _____ Male Female

Reason for consulting our office: _____

_____

Who may we thank you for referring you to us? _____

HEALTH PROFILE

Why is this form important? *As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you & your child the opportunity of imporved health potential & wellness services*

If your child has no symptoms or complaints, and is here for wellness services, please check ☐; others need to briefly describe the chief area of complaint, including the effect it has on the child. _____

_____

_____

If he/she is experiencing pain, is it: sharp dull Comes & Goes Travels Constant

Since the problem has started, is it: About the same Getting better Getting worse

What makes it worse? _____

It interferes with: School Sleep Walking Sitting Hobbies Other: _____

Other doctors seen for this problem:

Chiropractor: _____ Medical Doctor: _____

Other: _____

Please list all medication(s) including dosage(s) your child is currently taking or surgeries that they have had:

_____

_____

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

1. Were there any complications to the pregnancy? _____

2. Was mom on any medications, prescription or over-the-counter? yes no

If yes, explain: _____

3. Did or mom or dad smoke during pregnancy? yes no Who? _____

4. Was the baby ever in the Breech position? yes no

5. How many ultrasounds were performed? _____

Birth and Delivery

1. Where was the baby born? Home Hospital Birthing Center Other: _____

2. Was the delivery: Vaginal C-Section Were any devices used? Forceps Vacuum

3. Was oxytocin/pitocin used? yes no Was an epidural administered? yes no

Infancy

1. Was the infant vaccinated? yes no

2. Was there any prolonged use of medicines or an inhaler? yes no

If yes, which? _____

3. Did the infant suffer any traumas such as serious falls or car accidents? yes no

4. Has the infant been under regular chiropractic care? yes no

Childhood years

1. Did the child have any childhood illnesses? yes no Explain: _____

2. Does the child play youth sports? yes no Which sport(s)? _____

3. Has the child had any surgery? yes no Explain: _____

4. Has the child fallen from a heigh over 3 feet? yes no Explain: _____

5. Was the child involved in any car accidents? yes no When? _____

6. Has there been any prolonged use of meds? yes no Explain: _____

7. Has the child suffered emotional traumas? yes no Explain: _____

Please give us any other health information you feel would be helpful: _____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examin and care for my child

Parents signature: _____ **Date:** _____

Healthy Lifestyles Wellness Center

Dr. Kris Kirby, DC *Dr. Cammie Svuba, DC* *Dr. Chase Johnson, DC*

CONSENT TO TREATMENT FORM

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responisbility to inform this office of any changes in medical status

* I hereby request and consent to treatment, procedures, and/or tests performed by Healthy Lifestyles Wellness Center, LLC and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of any procedure which the doctor feels at the time is in my best interest.

* I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signature _____ Date _____

For Minor Child: I authorize the licensed doctor and whoever he/she may designate as assistants to administer chiropractic care as deemed necessary to: _____

(Name) _____ (Relationship) _____