THE CHIROPRACTOR @ Castlebury
Natural Healthcare Solutions

Date:____/____/____ Child's Name: _____

Parent/Guardian Names: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone(parental):_____ Cell Phone: _____

Email address: _____

Whom may we thank for referring you to this office: _____

Birth Date: ____/____/____ Age:_____ Current Weight:_____ Sex: M F

REASON FOR PURSUING CHIROPRACTIC CARE

____ She/He is continuing ongoing care from another Chiropractor.

____ I recently had my spine checked and I see the value in getting my child checked.

____ I'm concerned about his/her health and I'm looking for answers.

____ I want to improve my child's immune function.

____ I have no idea why we're here. Please explain to me what you do for children.

____ She/He has a specific condition that concerns me.

Explain condition/symptom: _____

PRESENT HISTORY

In order to understand your child's current level of health, please check any of the following body signals which your child has or has had previously.

____Ear Infections ____ Allergies ____Asthma ____ Colic ____Chronic colds/cough

____ Headaches ____ADHD ____Bed Wetting ____Seizures ____Recurring Fevers

____Constipation ____Diarrhea ____Rashes ____Scoliosis ____Car Accident(s)

____Stomach/Digestive ____Temper Tantrums ____Learning Disorder

___Sleeping Problems ____Other (please describe):_____

List Prescription or Over the Counter Medications Now Taken:

_____

Known Allergies: _____

Immunization History:_____

How many prescriptions of antibiotics has your child taken in the last 6 months?_____

How many in his/her lifetime (estimate):_____

PRENATAL HISTORY

Childbirth caregiver(s): OB/GYN_____ Doula_____ Midwife_____

Location of birth: Hospital_____ Home_____ Birth Center_____

Medication used during birth: None_____ Pitocin_____ Epidural_____

Interventions during birth: Breaking water_____ Vacuum_____ Forceps_____

Position of baby at birth: Head down_____ Posterior_____ Breech_____

Length of labor:_____

Complications during pregnancy_____

Complications during delivery_____

Birth weight_____Birth height_____

According to the National Safety Council, approximately 50% of infants fall head first form a high place (bed, changing table, down stairs etc.) during the first year of life. Was this the case with your child? ____ No ____ Yes

List: _____

FEEDING HISTORY

Breast fed: Y / N How long_____

Formula fed: Y / N How long_____

Type of formula_____

Introduced solids at _____ months Cow's milk at _____ months

Food allergies/intolerances Y / N

_____

DEVELOPMENTAL HISTORY

Number of hours of sleep per night _____ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

Respond to sound_____ Follow object with eyes_____ Hold head up_____

Crawl_____ Sit alone_____ Roll over_____ Walk alone_____ Say words_____

Do you have any concerns about your child meeting any of their milestones?

Yes____ No_____ If yes, please explain: _____

Please check all those that apply to your child.

_____1. Has your child been more irritable?

_____2. Has your child had difficulty sleeping?

_____3. Has your child's sleeping pattern changed?

_____4. Has your child's digestion pattern changed (i.e. constipation/diarrhea)

_____5. Has your child's intake of food been less or more?

_____6. Has your child needed more parental attention/affection?

_____7. Has your child been more distant/less affectionate?

_____8. Has your child had trouble with learning or retaining information?

_____9. Has your child's attention or focus been shortened?

_____10. Has your child's balance or coordination been altered?

_____11. Have you noticed any changes in speech patterns?

_____12. Have you noticed any changes in breathing patterns?

_____13. Have you noticed any visional changes such as squinting?

_____14. Have you noticed a change in “playing” patterns?

_____15. Have you noticed any aggression/violence/acting out?

_____16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?

The Chiropractor at Castlebury Financial Agreement

Dear Patient:

The Chiropractor at Castlebury will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to The Chiropractor at Castlebury.

We wish to make it very clear that your health is your sole responsibility.

These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended.

I choose the following method of payment for my care at The Chiropractor at Castlebury:

_____ **CASH** - Payment is due at the time of services.

_____ **MEDICARE -** Payment is due at time of service. The Chiropractor at Castlebury will bill Medicare if requested.

_____ **INSURANCE POLICY COVERAGE** - Although I am totally responsible for charges I may incur at The Chiropractor at Castlebury, I will initially pay for my yearly deductible and the percentage agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.

I certify I have insurance with _____ and assign directly to The Chiropractor at Castlebury all insurance benefits otherwise payable to me for services rendered. I understand I am personally financially responsible for all services rendered by The Chiropractor at Castlebury whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Chiropractor at Castlebury may use my health information and may release such information to any insurance company, adjustor or attorney and their agents for the purpose of obtaining payment for services rendered by The Chiropractor at Castlebury, and I hereby release The Chiropractor at Castlebury of any consequence thereof.

My signature below also certifies I have been given the opportunity to receive a copy of The Chiropractor at Castlebury's HIPPA Privacy Practices and accept its terms.

PATIENT'S NAME: (please print)_____

SIGNED:_____ Date _____/_____/_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

IN ADDITION PLEASE SIGN THE ARBITRATION AGREEMENT PROVIDED