GREATER NORWICH CHIROPRACTIC

Greater Norwich Chiropractic welcomes you into our family of happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following. We look forward to working with you to improve the health of your family!

Demographic Information

Childs Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Childs SSN: _____

Date of Birth: _____ Weight: _____ Height: _____ Sex: _____

Pediatrician or Family Doctor:_____ Location: _____

Last Visit:_____ Reason for Last Visit: _____

How was the patient referred to this office? _____

Primary Guardian

Name: _____

Relationship to Child:_____ SSN:_____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Childs Insurance: _____ Policy Holder: _____

Current Conditions

Is this visit for a wellness check-up? YES or NO (If you chose NO, please complete the following section)

Is the child currently experiencing pain? YES or NO

How long has the pain been present? _____

Where is the pain? _____ Does the pain: ___ Stay in one spot or ___ Travel

Has this condition occurred before? YES or NO If YES, when: _____

Has the child been treated by other doctors for this condition: YES or NO

If YES, which doctor? _____ When: _____

How is the condition now? _____ Same ____ Worse ____ Better ____ On and Off

Past History

Check any of the following conditions your child has suffered from in the past:

___ Ear Infections ___ Bed Wetting ___ Recurring Fever ___ Heart Conditions

___ Asthma/Allergies ___ Seizure ___ Temper Tantrums ___ Sinus Issues

___ Colic ___ADHD ___ Headaches ___ Trouble Sleeping

___ Scoliosis ___ Car Accident ___ Growing/Back Pain

___ Digestive Problems ___ Chronic Colds ___ Vaccination Reaction ___ Issues with Arms or Legs

Other: _____

Has the child had a major fall? YES or NO If yes, please explain:

_____

_____

How many times has your child received antibiotics? _____ in the past 6 months? _____

Medications: _____

Medication Allergies: _____

Is/has your child been involved in any high impact or contact sports? YES or NO

List:_____

Has your child ever been involved in a car accident? YES or NO If YES, When? _____

Has your child been seen on an emergency basis? YES or NO

For what? _____

Other traumas: _____

Prior Surgery: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Medication during pregnancy or delivery: _____

Cigarette/Alcohol use during pregnancy? YES or NO

Location of Birth: _____ Hospital _____ Birthing Center _____Home

Birth Intervention: _____ Forceps _____ Vacuum extraction _____ C-Section

Explain any complications during delivery: _____

Genetic Disorders: _____

Birth Weight: _____ Birth Length: _____

Feeding History

Breast Fed: YES or NO Formula Fed? YES or NO

Food/Juice Allergies or Intolerances: YES or NO

Please list: _____

Authorization for Treatment of a Minor

Greater Norwich Chiropractic and its affiliated doctors have permission to treat my child.

Child Name: _____ Parent/Guardian: _____

Signature: _____ Date: _____

Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health insurance information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.
- Visits may be videotaped to ensure quality control.
- At times, we offer adjustments in an open room setting with other patients present. Comments about your symptoms and/or progress maybe discussed during your office visits. If you have something private that you would like to discuss with the doctor, alert the staff and you will be offered a closed room.

We have a more complete notice that provides a more detailed description of how your health information may be used or disclosed. You have the right to view that notice before signing this consent form.

Your right to limit uses or disclosures: You have the right to request that we do not disclose your health information to certain individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information please let us know in writing. We are not required to agree to your restrictions.

Your right to revoke your authorization: You have the right to revoke your consent to us at any time. Your revocation must be in writing.

I have read the consent policy and agree to its terms. Initial _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will perform an examination with x-rays, if necessary, to determine a diagnosis and make treatment recommendations. If treatment is initiated, the doctor will use his/her hand and/or mechanical devices in an attempt to restore normal function to your joints and muscles. Various ancillary processes, such as hot/cold packs, electric muscle stimulation, therapeutic ultrasound or other soft tissue techniques may be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary process(s). Extremely rare complications could include muscle strain, ligamentous strain, injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice soreness or stiffness wit the first few treatments. The ancillary processes could produce skin irritation, burns or minor complications. Other treatment options which could be considered may include the following:

- Over the counter analgesics. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers, or other side effects in a significant number of cases.
- Medical care prescription anti-inflammatory drugs, muscle relaxers, and analgesics. Risks of these drugs include the above mentioned side effects and patient dependence on narcotics.
- Surgery, in conjunction with medical care, adds the risks of adverse reaction to anesthesia, death, as well as an extended convalescent period in a significant number of cases.

Risks or remaining untreated: Delay of treatment allows the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite possible that a delay in treatment will complicate your condition and make future rehabilitation more difficult.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions I have answered to my satisfaction. I have fully evaluated the risks and benefits or undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____