Mtn Home Spine & Health Solutions

Patient Information (CHILD)

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Birth Date: _____ /_____ /_____

City, State, Zip: _____ Cell Phone: ( ) _____

Name of Mother/Guardian: Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? □ Yes □ No If yes, when: _____ /_____ /_____

If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: □ Constant □ Intermittent □ Activity-related

Are they getting worse? □ Yes □ No Do they interfere with: □ School □ Sleep □ Hobbies/Play □ Daily Routine

Explain: _____

What activities aggravate these symptoms? _____

Is there anything that relieves your symptoms? □ Yes □ No If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? □ Yes □ No

If yes, explain: _____

_____

Has your child been treated for this? □ Yes □ No When was the last treatment? _____ / _____ / _____

Name of treating practitioner/facility? _____

What treatment(s) was performed? _____

_____

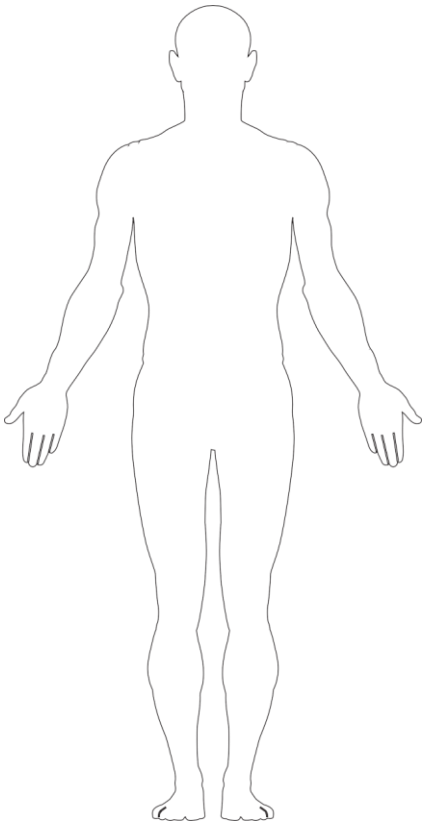
How did your child respond? _____

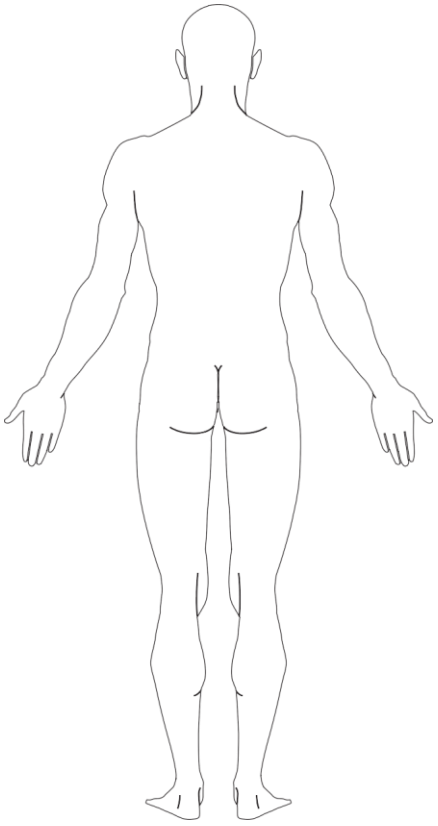
_____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING





P = PINS & NEEDLES	F = STIFFNESS	O = OTHER

FRONT BACK

If you marked "O" for Other on any part, please explain below:

_____

_____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident (***if you check this item, please ask the front desk person for the corresponding form***)
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s): _____

_____

Birth Experience:

How long was labor? _____

Describe any complications: _____

_____

Type of delivery: □ Vaginal □ C-Section □ Vacuum Extraction □ Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: ____ □ Mos. □ Yrs. Where received: _____
2. _____ Age: ____ □ Mos. □ Yrs. Where received: _____
3. _____ Age: ____ □ Mos. □ Yrs. Where received: _____
4. _____ Age: ____ □ Mos. □ Yrs. Where received: _____
5. _____ Age: ____ □ Mos. □ Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site	____ Body rash or hives	____ High fever (over 103 degrees)
____ High-pitched screaming	____ Extreme sleepiness or unresponsiveness	____ Body twitching or paralysis
____ Breathing problems (asthma, etc.)	____ Excessive bleeding or anemia	____ Head banging
____ Excessive diarrhea or chronic constipation	____ Loss of memory/foggy state	____ Muscle weakness
____ Chronic ear or respiratory Infections	____ Vision or hearing disturbances	____ Joint pain
____ Crossing of eyes	____ Seizures	____ Other (please explain)

Explanation(s): _____

_____

_____

_____

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.*

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Colic
____ Sore throats
____ Auto-Immune Diseases
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Ear Infections
____ Learning disabilities
____ Other (please explain)
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking
____ Flu/Stomach disorders
____ Hyperactivity/ADD

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Heart Murmurs
____ Tachycardia
____ Heart Attacks/Angina
____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn/Reflux
____ Recurrent Lung Infection/Bronchitis
____ Asthma/Wheezing
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Nausea
____ Ulcers/Gastritis
____ Diabetes
____ Hypoglycemia/Hyperglycemia

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in your legs/feet
____ Frequent/difficulty urinating
____ Menstrual irregularities/cramping (females)
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
_____ Other (please explain)
____ Low back pain
____ Coldness in legs/feet
____ Constipation/Diarrhea

OTHER

Please list any health conditions not mentioned: _____

_____

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).***:

____ ADD	____ Allergies/Hay fever*	____ Anemia	____ Appendectomy
____ Arthritis	____ Asthma	____ Bed wetting	____ Blood sugar problems
____ Broken bones/fractures	____ Cancer	____ Cerebral Palsy	____ Chicken pox/shingles
____ Circulatory problems	____ Crohn's/Colitis	____ Depression	____ Diabetes
____ Ear Infections	____ Eczema	____ Eczema/Psoriasis	____ Epilepsy/seizures
____ Fetal drug exposure	____ Food allergies*	____ Gall bladder	____ Headaches
____ Heart disease	____ Heart murmur	____ Hepatitis	____ Hernia
____ High blood pressure	____ HIV	____ Infectious disease	____ Influenza
____ Kidney Disease	____ Liver disease	____ Lumbago	____ Lung disease
____ Measles	____ Metal implants	____ Migraine headaches	____ Mumps
____ Neurological problems	____ Osteoporosis	____ Paralysis	____ Pleurisy
____ Pneumonia/Bronchitis	____ Polio	____ Rash	____ Rheumatic fever
____ Scoliosis	____ Seizure disorder	____ Sickle cell anemia	____ Smallpox
____ Spinal Bifida	____ Stroke	____ Thyroid problems	____ Tonsillectomy
____ Tuberculosis	____ Varicose veins	____ Whooping cough	____ Other*

Explanation of (*) item(s):

_____

Experience with Chiropractic

Has your child seen a Chiropractor before? □ Yes □ No Who? _____

Reason for visit(s): _____

Did the previous chiropractor take 'before' and 'after' x-rays? □ Yes □ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? □ Yes □ No Did they recommend a Home Health Care program? □ Yes □ No

If yes, what? _____

How long was your child treated? _____ Last treatment: _____ / _____ / _____

How did your child respond? _____

Are you aware of any poor posture habits in your child? □ Yes □ No Is there any history of spinal problems in your family? □ Yes □ No

If yes, explain: _____

_____

_____

Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____/ _____ / _____

Guardian Signature _____ Date _____/ _____ / _____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that he/she will not receive the full benefit from these programs; and that if I terminate this care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date __ / _____ / _____

Patient's Name Printed _____

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____/ _____ / _____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? □ Yes □ No

Signature of Person Authorizing Care:

_____ Date _____ / _____ / _____

Relationship to Insured _____ Date of Birth _____ / _____ / _____

Employer _____

Primary Insurance Company_____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____

Secondary Insurance Company_____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____