PERSONAL INFORMATION

First Name: ______________________________ MI ____ Last Name: ____

Address: ____ Age: __________ Gender:M F

City/State/Zip: ____ Birth Date: _____ / _____ / ____

*Email (required): ____ Cell/Home Phone: ________________________

*You will automatically be enrolled to receive **protected** health records through **Office Ally**. This allows you to gain online access to your medical records.

Name of Mother/Guardian: ____________________________________ Cell/Home Phone:________________________

Birth Date: ______ / _____ / _____ Marital Status: ❑S ❑M ❑D ❑W Work Phone: ____________________________

Address (if different): ____________________________________ City/State/Zip: _________________________________

Occupation: _____________________________________ Employer's Name: _____________________________________

Name of Father/Guardian: ____________________________________ Cell/Home Phone:________________________

Birth Date: ______ / _____ / _____ Marital Status: ❑S ❑M ❑D ❑W Work Phone: ____________________________

Address (if different): ____________________________________ City/State/Zip: _________________________________

Occupation: _____________________________________ Employer's Name: _____________________________________

How were you referred to our office?: ❑TV ❑Drive By ❑Internet ❑Insurance Co.

❑Friend/Family: ________________________ ❑Other: ___________________

Pediatrician Name/Practice Name: ____ Phone: ____________________

Has your child seen a Chiropractor before? ❑Yes ❑No If Yes, When: ____

Where: ____ Results: ____

Are you aware of any poor posture habits in your child? ❑Yes ❑No

If yes, explain: ____

Please List Your Child's TOP 2 Complaints/Symptoms

Complaint #1	Type of Pain:		Worse with which of these activities:		Result of:
______________________ ______________________ Began?: ______________ Has he/she had this before? ❑ Yes ❑ No Is it Getting Worse? ❑ Yes ❑ No ❑ Constant	❑ Aching ❑ Burning ❑ Deep ❑ Dull ❑ Numb ❑ Sharp/ Stabbing	❑ Tight ❑ Stiff ❑ Tender ❑ Tingling ❑ Throbbing ❑ Shooting ❑ Sore	❑ Lying on back ❑ Lying on side ❑ Lying on stomach ❑ Turning over ❑ Getting in/out of car ❑ Dressing self ❑ Pushing ❑ Pulling ❑ Lifting ❑ Reaching	❑ Stooping ❑ Bending ❑ Twisting/Turning ❑ Sitting ❑ Standing ❑ Walking ❑ Climbing ❑ Sneezing ❑ Coughing ❑ Other: _________	❑ Auto Accident ❑ Injury/Fall ❑ Other (Describe): ______________ ______________

Complaint #2	Type of Pain:		Worse with which of these activities:		Result of:
______________________ ______________________ Began?: ______________ Has he/she had this before? ❑ Yes ❑ No Is it Getting Worse? ❑ Yes ❑ No ❑ Constant	❑ Aching ❑ Burning ❑ Deep ❑ Dull ❑ Numb ❑ Sharp/ Stabbing	❑ Tight ❑ Stiff ❑ Tender ❑ Tingling ❑ Throbbing ❑ Shooting ❑ Sore	❑ Lying on back ❑ Lying on side ❑ Lying on stomach ❑ Turning over ❑ Getting in/out of car ❑ Dressing self ❑ Pushing ❑ Pulling ❑ Lifting ❑ Reaching	❑ Stooping ❑ Bending ❑ Twisting/Turning ❑ Sitting ❑ Standing ❑ Walking ❑ Climbing ❑ Sneezing ❑ Coughing ❑ Other: _________	❑ Auto Accident ❑ Injury/Fall ❑ Other (Describe): ______________ ______________

HEALTH & LIFESTYLE

Is this condition interfering with your (Check all that apply):

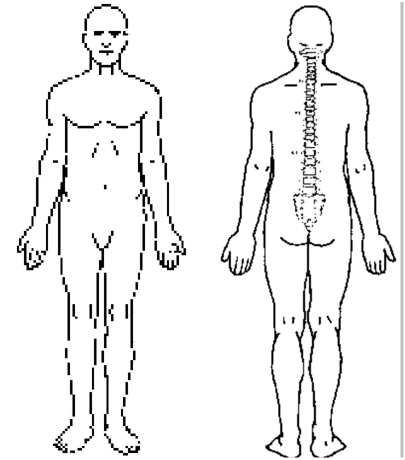
❑ School ❑ Sleep ❑ Daily Routine ❑ Hobbies/Play ❑ Other: ___________

Have you received any treatment for this condition? ❑ Yes ❑ No

If Yes, please explain: ____

____

Please "X" your areas of pain on the figures below:



HABITS

❑ Soft Drinks	Drinks/Day: ____________________
❑ Water	Glasses/Day: ____________________
❑ Vitamins	List: ____________________
❑ Sports	List: ____________________
❑ Hobbies	List: ____________________

EXERCISE

❑ None
❑ 1-2 days/week
❑ 3-4 days/week
❑ 5+ days/week
Type of Exercise:
____
____

EMERGENCY CONTACT

Name: ______________________________ Relation: ______________________________

Cell/Home Phone: ______________________________ Work Phone: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

ELECTRONIC HEALTH RECORDS (EHR) INFORMATION

Demographics

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Preferred Language: ❑ English ❑ Spanish ❑ Other: ____________________

Race: ❑ White/Caucasian ❑ African American ❑ Native American ❑ Hawaiian/Pacific ❑ Asian ❑ Other: ________________

Are you allergic to any medications? Yes No

If yes, please list those medications and the problem experienced?

____

____

____

Do you smoke now?	Yes	No
Have you ever been a smoker?	Yes	No
Use any other form of tobacco?	Yes	No

CHECK THE FOLLOWING HEALTH CONDITIONS AS THEY APPLY TO YOU

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck 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 if you have had any of these conditions in the Past, Now, or Both.**

Past	Now		Past	Now		Past	Now	
❑	❑	Neck Pain	❑	❑	Low energy/fatigue	❑	❑	Sinus congestion/infections
❑	❑	Pain in shoulders/arms/hands	❑	❑	Sore throats	❑	❑	Hearing disturbances
❑	❑	Numbness/tingling in arms/hands	❑	❑	Anxiety/Depression	❑	❑	Visual disturbances
❑	❑	Weakness in grip	❑	❑	Sleep problems	❑	❑	Dizziness/vertigo
❑	❑	Cold hands	❑	❑	Recurrent Colds/Flu	❑	❑	Thyroid conditions
❑	❑	Headaches/Migraines	❑	❑	Allergies/hay fever	❑	❑	TMJ/Pain/Clicking
❑	❑	Colic	❑	❑	Hyperactivity/ADD	❑	❑	Learning Disabilities

Please explain: ____

____

____

HEALTH CONDITIONS CONTINUED…

THORACIC SPINE (MID AND UPPER BACK)

Misalignment of the individual vertebrae or distortion of the thoracic curve (upper and mid back) originating in the mid 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 if you have had any of these conditions in the Past, Now, or Both.**

Past	Now		Past	Now		Past	Now	
❑	❑	Upper Back Pain/Stiff/Tight	❑	❑	Shortness of breath	❑	❑	Ulcers
❑	❑	Mid Back Pain/Stiff/Tight	❑	❑	Asthma/wheezing	❑	❑	Gas
❑	❑	Tachycardia (racing heart)	❑	❑	Lung Infections/Bronchitis	❑	❑	Nausea
❑	❑	Palpitations	❑	❑	Pain w/ deep breaths	❑	❑	Stomach aches/cramping
❑	❑	Heart Murmurs	❑	❑	Pain in ribs/chest	❑	❑	Diabetes
❑	❑	Liver Problems	❑	❑	Heartburn/Reflux	❑	❑	Gall Bladder Problems
❑	❑	Spleen Problems	❑	❑	Tired/irritable after eating or when not having eaten for awhile			

Please explain: ____

____

____

LUMBAR SPINE/PELVIS (LOW BACK/HIPS)

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 if you have had any of these conditions in the Past, Now, or Both.**

Past	Now		Past	Now		Past	Now	
❑	❑	Low Back Pain	❑	❑	Cold feet	❑	❑	Frequent/difficulty urinating
❑	❑	Pain in the hips/legs/feet	❑	❑	Muscle cramps in leg/feet	❑	❑	Unable to control urine
❑	❑	Numbness/Tingling in legs/feet	❑	❑	Constipation	❑	❑	(Females) Irregular cycles/ cramping
❑	❑	Weakness/injuries in hips/ knees/ankles	❑	❑	Diarrhea	❑	❑	Kidney stones
			❑	❑	Recurrent bladder infections			

Please explain: ____

____

____

ADDITIONAL INFORMATION

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

____

____

____

____

Please list any other health conditions, diseases, or surgeries (tonsils, appendectomy, cancer, epilepsy, etc): ___________

____

____

____

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the vertebrae, soft tissue injury to the supportive structures of the spine, and shifts in whole curves and section 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 an 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
_______ Experienced broken bones or debilitating injuries*
_______ Difficult Birth (see below)

Explanation of (*) item(s): ____

____

BIRTH EXPEREINCE:

How long was labor? ____

Describe any complications: ____

____

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

VACCINATION HISTORY

Date of your child's last vaccination (if applicable): ____________________ What was received: ________________________

Please check any of the following responses your child experienced as a result of a vaccination. Please explain below which vaccination caused the condition.

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

Please explain: ____

____

____

FAMILY HISTORY

Please √ all that apply

	Stroke	Bad Posture	Heart Trouble	High Blood Pressure	Cancer	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Diabetes	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis
Father															
Mother															
Brother															
Sister															

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on my child by Westphalia Chiropractic and staff who now or in the future treat me while employed by Westphalia Chiropractic.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my child's condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my child's symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment.

______________________________ ______________

Patient Signature Date Signed

______________________________ ______________________________ ______________

Guardian Name & Relationship to Patient Guardian Signature Date Signed

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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: ____________________

______________________________ ______________

Patient Signature Date Signed

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize the doctor and whomever he/she may designate as assistance to administer chiropractic care as he/she deems necessary to my child.

______________________________ ______________

Signature of Parent or Guardian Date Signed

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Westphalia Chiropractic's "Notice of Privacy Practices" published April 14, 2003 has been provided to me.

I understand I have a right to review Westphalia Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Westphalia Chiropractic.

The Notice of Privacy Practices for Westphalia Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Total Health Spine & Nutrition's duties with respect to my protected health information.

Westphalia Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Westphalia Chiropractic's website.

I have the right to revoke this consent, in writing, except to the extent that Westphalia Chiropractic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

____ ________________
Patient Signature or Personal Representative Date Signed

____
Description of Personal Representative's Authority

PATIENT INFORMATION RELEASE AUTHORIZATION

I hereby authorize Westphalia Chiropractic to release information contained in my patient records to the individual(s) and only under the conditions listed below:

Name of person(s) to whom information can be disclosed to (i.e. spouse, family member, friend, another doctor, etc):

____

____

Specific type of information to be disclosed (i.e. all records, x-rays, blood tests, etc):

____

____

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

______________________________ ____________________
Patient Signature Date Signed

______________________________ ____________________
Parent or Guradian Signature Date Signed

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Westphalia Chiropractic. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Spine & Nutrition responsible for any errors or omissions that I may have made in the completion of this form.

____________________________________ ____________________

Patient Signature Date Signed

____________________________________ ____________________

Parent or Guardian Signature Date Signed