Amplus FAMILY CHIROPRACTIC

Children's Health History

Your Child's Personal Information

Name _____ Age _____ Date of Birth _____ Gender _____

Home Address _____ City _____ State____ Zip _____

Names and ages of siblings _____

Parent A Information

Name _____

Home Phone _____

Cell Phone _____

Email _____

Employer _____

Work Phone _____

Parent B Information

Name _____

Home Phone _____

Cell Phone _____

Email _____

Employer _____

Work Phone _____

Whom may we thank for referring you to our office? _____

How old is/was your child's oldest grandparent or relative? _____

☐ Still living ☐ Deceased

Health Care Practitioner History

Has your child ever received chiropractic care? ☐ Yes ☐ No Reason _____

Name of previous chiropractor _____ Date of last visit _____

How long were you under care? _____ Why was care stopped? _____

Were you pleased with care? ☐ Yes ☐ No Please Explain _____

_____

_____

Does your child have a…? ☐ Pediatrician ☐ Pediatric Naturopath

If so, what is the doctor's name? _____ Date of last visit _____

Reason for Seeking Chiropractic Care

What is your child's present complaint or concern? If no current complaint, what is the reason for the visit today?

_____

When did this condition begin? _____

How did the condition start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is the condition: ☐ Getting Worse ☐ Improving ☐ Constant ☐ Intermittent ☐ Unsure

What makes the condition better? _____

Amplus FAMILY CHIROPRACTIC

What makes the condition worse? _____

Is the condition worse during certain times of the day? ☐ No ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Is this condition interfering with: ☐ School ☐ Sleep ☐ Playing ☐ Exercise/Sports ☐ Communication

☐ Eating ☐ Attention/Focus

Has your child ever had a similar condition? ☐ Yes ☐ No Please Explain _____

_____

Who has your child seen for this condition? _____

Were you pleased with care? ☐ Yes ☐ No Please Explain _____

Please check if your child has experienced any of the following conditions:

☐ ADHD
☐ Asthma
☐ Allergies
☐ Auto Accident
☐ Bed Wetting
☐ Behavioral Problems
☐ Colic
☐ Constipation
☐ Dental Problems
☐ Digestive Problems
☐ Depression
☐ Ear Infection
☐ Fainting
☐ Fatigue/Low Energy
☐ Frequent Colds/Flus
☐ Growing Pains
☐ Irritability
☐ Loss of Balance
☐ Poor Coordination
☐ Poor Posture
☐ Recurring Fevers
☐ Scoliosis
☐ Seizures
☐ Sleeping Problems
☐ Sensitivity to Light
☐ Temper Tantrums
☐ Vision Changes
☐ Walking Trouble

Other health concerns? _____

Medical History

Please list any injuries, accidents, falls and/or fractures your child has had in his/her lifetime _____

_____

In/Out-Patient/Hospitalizations/Surgical history _____

_____

Have you chosen to vaccinate your child? ☐ Yes ☐ No

Please describe any and all reactions to any vaccine(s) _____

_____

Please check all that apply to your child and give any necessary details:

☐ Uncoordinated/Accident Prone _____

☐ Has/had a chronic illness _____

☐ Has allergies _____

☐ Has taken antibiotics _____

☐ Currently taking medication _____

☐ Currently taking supplements/vitamins/herbs _____

Amplus FAMILY CHIROPRACTIC

Pregnancy & Birth

Our ☐ Obstetrician ☐ Midwife ☐ Family Physician was _____

During pregnancy, did you/the mother:

Experience any significant illnesses, difficulties, or trauma? ☐ Yes ☐ No If yes, please explain _____

_____

Take any drugs/medications/supplements? ☐ Yes ☐ No If yes, please explain _____

_____

Smoke or consume alcohol? ☐ Yes ☐ No If yes, please explain _____

_____

Have any exposure to ultrasound? ☐ Yes ☐ No If yes, please explain _____

_____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ☐ Yes ☐ No If yes, please explain _____

_____

Was your child in a breech position or otherwise malpositioned? ☐ Yes ☐ No

If yes, please explain _____

Please check where/how your child was born and if any of the following were administered during labor and birth:

☐ Home Birth
☐ Birthing Center
☐ Water Birth
☐ Hospital Birth
☐ Vaginal
☐ Scheduled Caesarean
☐ Emergency Caesarean
☐ Epidural
☐ Forceps
☐ Vacuum
☐ Episiotomy
☐ Cord around neck
☐ Manual traction of neck

☐ Medications _____

☐ Other _____

Was the birth premature? ☐ Yes ☐ No Weeks _____ Was there delayed cord clamping? ☐ Yes ☐ No

Child's Birth Weight _____ Child's Birth Length _____ Current Weight _____ Current Height _____

Please check all that apply to your child's status immediately after birth:

APGAR Score _____ /_____

☐ Jaundice
☐ Respiratory Problems
☐ Feeding Problems
☐ Displaced Joints
☐ Odd Shaped Head

☐ Broken Bones _____
☐ Other conditions _____

Amplus FAMILY CHIROPRACTIC

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _____

_____

Does your child have any genetic disorder or disabilities? ☐ Yes ☐ No If yes, please explain _____

_____

At what age did your child:

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____

Site alone _____ Teethe _____ Cross crawl _____ Walk _____

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? _____

If breastfed, any difficulty with breastfeeding? ☐ Yes ☐ No ☐ N/A If yes, please explain _____

_____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solids at age _____

Please list any foods/juice intolerance _____

Any difficulty with bonding? ☐ Yes ☐ No If yes, please explain _____

_____

Any behavioral problems? ☐ Yes ☐ No If yes, please explain _____

_____

Any night terrors, sleep walking or difficulty sleeping? ☐ Yes ☐ No If yes, please explain _____

_____

Has your child been involved in any high impact or contact-type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No If yes, please explain _____

_____

Describe your child's diet? ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amounts of processed foods

Does your child have regular bowel/bladder movements? ☐ Yes ☐ No

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?

☐ Yes ☐ No If yes, please explain _____

_____

Age of your child when he/she began daycare? _____ ☐ N/A

Average number of hours of TV/computer/iPad/technology per week? _____

Amplus FAMILY CHIROPRACTIC

Please indicate if your child has ever or currently experiences any of the emotional stresses below: (check all that apply)

- ☐ Academic Pressure
- ☐ Bullying
- ☐ Loss of a loved one
- ☐ Relocation
- ☐ Parents' Divorce
- ☐ Lifestyle change
- ☐ New Sibling

Are there any other health concerns or anything else you'd like us to know about your child? _____

_____

_____

Your Child's Top 3 Health Goals

Please tell us your child's top 3 health goals: (i.e. perform well in school, sleep better, become more active, etc…)

1. _____
2. _____
3. _____

Expectations of Care

I would like my child to experience the following benefits from chiropractic care (Please check all that apply)

- ☐ Feel better quickly
- ☐ Correct the cause of a problem as well as relief
- ☐ Prevent future problems
- ☐ Live a healthier lifestyle
- ☐ Healthier spine and nervous system
- ☐ Optimal health on all levels
- ☐ Other _____

Thank you for trusting us at Amplus Family Chiropractic to help you and your family achieve a life of abundance.

Amplus
FAMILY CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care for my child on this basis.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name: (Printed) _____

Signature _____ Date _____

Amplus FAMILY CHIROPRACTIC

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange and agree to a recommended care plan payment schedule in advance. These plans are designed to be the most affordable way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition, and Lifestyle Care options. Details of these plans will be discussed with you during your Report of Findings on your second visit. Please choose one of the following documentation options:

☐ Insurance: If you have insurance that covers chiropractic care, we will give you all of the information you need to get reimbursed. This includes your diagnosis codes and details of charges on a specialized receipt called a superbill. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your second visit and then once per month after that. Just send your superbill to your insurance company, and they will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

☐ No Insurance: If you do not have health insurance, choose not to use your health insurance, or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

I have read and understand the above policy. I have indicated the option that applies to me.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name: (Printed) _____

Signature _____ Date _____

Healthcare Authorization

The following authorizes Amplus Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

- I give permission to Amplus Family Chiropractic to use my name, address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, patient of the week/month postings, information about treatment alternatives or other health related information.
- If Amplus Family Chiropractic contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voicemail.
- I give permission to Amplus Family Chiropractic to use my first name on a welcome board, referral board, birthday board, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website, ads in print media, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to use any testimonial written by me for marketing purposes such as; sharing with other patients or potential patients, in their brochure, on their website, ads in print media, and social media (Facebook, Instagram, etc.).
- I give permission to Amplus Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Amplus Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: * The right to review the notice prior to signing this consent * The right to object to the use of my health care information for directory purposes * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Consent to Care

I do hereby authorize the doctor(s) of Amplus Family Chiropractic to administer chiropractic care that is necessary for my child's particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my child's health care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, Amplus Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. Amplus Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Child's Name: (Printed) _____

Your Name: (Printed) _____

Signature _____ Date: _____