CHILD APPLICATION FOR CARE

Alive Chiropractic
12930 W Bluemound Rd
Elm Grove, WI, 53122
262.955.8867

Today's Date: _____/_____/_____

Name: _____ Birth Date: ____/____/____ Age: ____ Male/Female

Weight: _____ Height: _____

Guardian(s) Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Email Address: _____

Has your child seen a chiropractor before? ☐ Yes ☐ No If yes, when?: _____

Does your child have insurance? ☐ Yes ☐ No Primary Insurance: _____

Secondary Ins.: _____ Name of Insured: _____

How did you hear about our office?: _____

HEALTH HISTORY: Please ✔ check all symptoms your child has ever had, even if they do not seem related to their complaint:

___Headaches	___ Thyroid Issues	___ Sleep Problems	___ Heart Problems	___ Constipation
___ Ear Infections	___ Torticollis	___ Nausea	___ Lower Back Pain	___ Poor Posture
___ Sinus Issues	___ Allergies	___ Seizures	___ Nervousness	___ Spinal Surgery
___ Kidney Problems	___ Neck Pain	___ Excessive Tantrums	___ Digestive Issues	___ Knee (L/R)
___ Numb/Tingling	___ Dizziness	___ Upper Back Pain	___ Disc problems	___ ADD/ADHD
Arms/Hands (L/R)	___ Asthma	___Double/Blurry Vision	___ Cancer	___ Bed Wetting
___ Migraines	___ Autism	___ Ulcers	___ Hip/Leg Pain (L/R)	___ Skin Problems
___ Hearing Loss	___Behavioral Issues	___ Epilepsy	___ Depression	___ Diabetes (1 or 2)
___ Frequent Colds	___ Shoulder Pain (L/R)	___ Convulsions	___ Diarrhea	___ Foot (L/R)
___ Colic	___ Loss of Energy	___ Reflux	___ Scoliosis	___ Arthritis/Joint Pain
___ Numb/Tingling	___Difficulty Breathing	___ Mid Back Pain	___ Spinal Fracture	___ Bladder Problems
Legs/Feet (L/R)	___ Sensory Issues	___ Anxiety	___ Bone Facture	___ Other:
___ Jaw/TMJ Pain	___ Mood Swings	___ Stomach Issues	___ Sciatic Pain (L/R)	_____
___ Ringing in the Ears	___ Elbow/Wrist Pain	___ Tremors	___ Loss of Balance	_____

Main Complaint: _____

List any medications presently taking: _____

Has your child been in a car accident recently? Yes No If so, when?: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation.

Parent/Guardian Signature: _____ Date: _____ (if under 18 years)

Pregnancy Information:

How was your pregnancy? _____

Any Pregnancy Complications? _____

Did you take any medication during your pregnancy? _____

Other Information: _____

Delivery Information:

Location of Birth: (circle one) Hospital Birth Center Home

Birth Intervention: (circle one) Induction Forceps Vacuum Extraction Caesarean Section

_____

Induced? Yes / No Explain: _____

Medications during delivery? _____

Other Information: _____

Post Birth Information:

Birth Weight: _____ Birth Length: _____

Breast Fed: Yes / No How long? _____ Formula Fed: Yes / No How Long? _____

Introduced Solid Foods at _____ months

Food Allergies or intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months _____ Lifetime _____

Over the counter drugs (Tylenol, Cough Syrup, Laxatives, etc.) _____

_____

List all Surgical operations / hospitalizations / slips/falls and year of occurrence: _____

_____

Has your child ever been knocked unconscious? ☐ Yes ☐ No Fractured a bone? ☐ Yes ☐ No

If yes to either of the above, please describe: _____

_____

Does your child have difficulty turning their head? ☐ Yes ☐ No If yes, which way? _____

Does your child arch their neck/back or have involuntary movements or restriction with movements? _____

_____

Activities of Life

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their life or milestones they are struggling to meet.

List Restricted Activity	Current Activity Level	Usual Activity Level
Example: Crawling all around	Not crawling hardly at all	They used to be able to crawl no problem

Quadruple Visual Analogue Scale

Please **circle** the number that best describes the question asked for your **MAIN COMPLAINT.**

1. How would you rate your pain **RIGHT NOW**?

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical **AVERAGE** pain?

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to my child, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Robert Fugiel, D.C., and any and all providers from Alive Chiropractic I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below

Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Robert Fugiel and any and all Alive Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Alive Chiropractic.

Parent/Guardian Signature: _____ Date: _____

Relationship to Minor/Child: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays on a disc for a $5 fee. This fee must be paid in advance.

PLEASE NOTE: X-rays are utilized in this office to help locate and analyze **vertebral subluxations**. The doctor(s) of Alive Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Child's Full Legal Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)