Ages infant to 4

Peak Family Chiropractic LLC.

132 Merz Blvd. Fairlawn, Ohio 44333
(330) 670-9400(p) ~ (330) 670-9401 (f)

Date: _____

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

Patient Information

Name:_____ _____ _____ Date of Birth:_____ Age:_____
Last First MI

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

Home Phone:_____ Cell Phone:_____ Cell Phone Carrier:_____

Email:_____

Mother's Name: _____ Mother's Occupation:_____ Mother's Phone:_____

Father's Name:_____ Father's Occupation:_____ Father's Phone:_____

In Case Of Emergency, Contact:

Name:_____ Relationship:_____ Contact Number:_____

Health Insurance Information

Name of Insurance Company: _____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Name of Secondary Insurance:_____ Policy Number:_____

Name of Insured (Policy Holder) _____ Group Number:_____

Insured Date of Birth: _____

Is your office visit due to an auto accident or work injury? ☐ Yes ☐ No If yes, which one applies? ☐ Auto accident ☐ Work Injury

Current Health Conditions

Purpose of Visit? ☐ Wellness Checkup? ☐Other:_____

Other Doctors seen for this condition: ☐Yes ☐No

Name of Physician:_____ Treatment Received:_____
Name of Physician:_____ Treatment Received:_____
Name of Physician:_____ Treatment Received:_____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ ADHD	☐ Temper tantrums	☐ Asthma/Allergies
☐ Digestive problems	☐ Car Accident	☐ Chronic Colds	☐ Colic
☐ Bed Wetting	☐ Seizures	☐ Headaches	☐ Other:_____
☐ Scoliosis	☐ Recurring fevers	☐ Growing/Back Pains	

Prenatal History

Name of Obstetrician/Midwife:_____

Did you experience any complications during your pregnancy? (Check all that apply)

☐ Back/Other Pain	☐ Fatigue	☐ Strep B	Other:_____
☐ Pre-Term	☐ Pre-Eclampsia	☐ Nausea/Vomiting	
☐ Gestational Diabetes	☐ Swelling		

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Did you have Ultrasounds during your pregnancy? ☐Yes ☐No Number:_____

Did you have medications during pregnancy/delivery? ☐Yes ☐No List:_____

Cigarette/Alcohol use during pregnancy? ☐Yes ☐No

Location of Birth: ☐ Hospital ☐Birthing Center ☐Home

Birth Interventions: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section ☐Emergency ☐ Planned ☐ Vaginal

Type of Birth/Complications preceding birth: (check all that apply)

- ☐ Antibiotics
- ☐ Respiratory Distress
- ☐ Congenital Abnormalities
- ☐ Extended Hospitalization
- ☐ Failure to Thrive
- ☐ Jaundice
- ☐ Meconium
- ☐ Other: _____

Genetic disorders or disabilities: ☐ Yes ☐No List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____,_____

Feeding History

Breast Fed: ☐ Yes ☐ No How long:_____

Formula Fed: ☐ Yes ☐No How long:_____

Introduced to solids at: _____ Months, Introduced to Cow's Milk at:_____ Months Introduced to Protein at:_____ Months

Food/Juice allergies or intolerances: ☐ Yes ☐ No If so, List:_____

Development History/Family History

During the following times, your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation(spinal nerve interference). **At what age was your child able to:**

_____ Respond to stimuli (sounds and touching) _____ Respond to Visual Stimuli _____ Respond to visually _____ Hold Head up
_____ Sit up _____ Cross Crawl _____ Stand Alone _____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. A bed, changing table, down stairs, etc.)

Was this the case with your child? ☐ Yes ☐ No If yes, please describe: _____

Has your child ever been in a car accident? ☐Yes ☐No If yes, please describe:_____

Has your child been seen on an emergency basis? ☐Yes ☐No If yes, please describe:_____

Does your child have other Traumas not described above? ☐Yes ☐No If yes, please describe:_____

Prior Surgery? ☐ Yes ☐ No If yes, please describe:_____

Have you vaccinated your child? ☐ Yes ☐ No If yes, do you follow the AMA schedule? ☐ Yes ☐ No

Has your child ever seen a Chiropractor? ☐ Yes ☐ No If yes, Name of Chiropractor: _____

Does your child take any medications? ☐ Yes ☐ No If yes, please list:_____

Family History:
Please list any conditions affecting your child's immediate family.
Mother:_____
Father:_____
Brothers:_____
Sisters:_____

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Consent to Treat

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Parent or Guardian: _____Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:_____

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HIPPA Acknowledgement

I acknowledge that I have reviewed/received a copy of Peak Family Chiropractic LLC's Notice of Privacy Practices.

_____
Name of Patient (Please Print)

_____ _____
Signature of Guardian Date

Authority of Personal Representative to Sign for Patient (check one)

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other:_____

Please note: It is your right to refuse to sign this Acknowledgement

Office Use Only

I tried to obtain written acknowledgement by the individual noted above of the receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgment.
__ The individual was unwilling to sign
__ Other: _____

_____ _____
Staff Member Signature Date

Financial Policy

Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

"ON THE JOB" INJURY (Workman's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees for services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. Our office completes and files the forms for Medicare at no cost.

SUBMITTING CHARGES TO INSURANCE
The providers Peak Family Chiropractic want to decide what care is in the best interest of each individual patient. For that reason, Peak Family Chiropractic and its providers are not a participating with your insurance company unless listed above. Under no circumstance will we submit claims to your insurance company for your care. If you would like to submit claims to your insurance, we will supply you a superbill upon request.

I have read and understand the payment policy of Peak Family Chiropractic.

Guardian Signature Date

DO NOT WRITE BELOW THIS LINE

Patient Name: Date of Birth: Act. Number: Date:

Supine Leg Length Check_____

Infant Reflexes- Under 1	***Right***	***Left***
Rooting	P A	P A
Sucking	P A	P A
Nasopalperbral	P A	P A
Blink	P A	P A
Pupilary	P A	P A
Head Control	P A	P A
Tonic Neck	P A	P A
Neck righting	P A	P A
Otolith righting	P A	P A
Palmar Grasp	P A	P A

P- Present A- Absent

Palpation Exam

OCC	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**				
T1	**T2**	**T3**	**T4**	**T5**	**T6**	**T7**	**T8**	**T9**	**T10**	**T11**	**T12**
L1	**L2**	**L3**	**L4**	**L5**							
SAC	**LI**	**RI**									

Physician Notes:
_____
_____
_____
_____
_____
_____
_____
_____

Signature:_____ Date:_____