Pediatric Patient Introduction
Ages 5-17

Name: ______________________________ Date of Birth ____/____/____

Address: ______________________________ Male / Female

____

Mother' Name: ______________________ Best Number in which to contact you: ______________

Father's Name: ______________________ Best Number in which to contact you: ______________

Home: ______________________________

Email: ______________________________

Emergncy Contact (different from parent) ______________________________

Phone: ______________________________

Siblings Names & Ages ______________________________

____

Consent to Initiate Care

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 examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with 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.
(Please Print Name of Parent/Guardian)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient ____________________________________, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given. I agree to pay for all services rendered in this office.

____

Parent/Guardian Name | Parent/Guardian Signature | Date

I. General Information

How did you hear of our office?

Business Card   Web Search   Doctor   Friend   Fitness Center   Event

Who may we thank for referring you? ____________________

Have you ever been to a Chiropractor before?   Yes   No

Date of Last visit: ____________   Reason for Care: ____________________

How long were you under care: ________   Were x-rays taken?   Yes   No

II. Chief Complaint

Reason for seeking Chiropractic Care today: ____________________

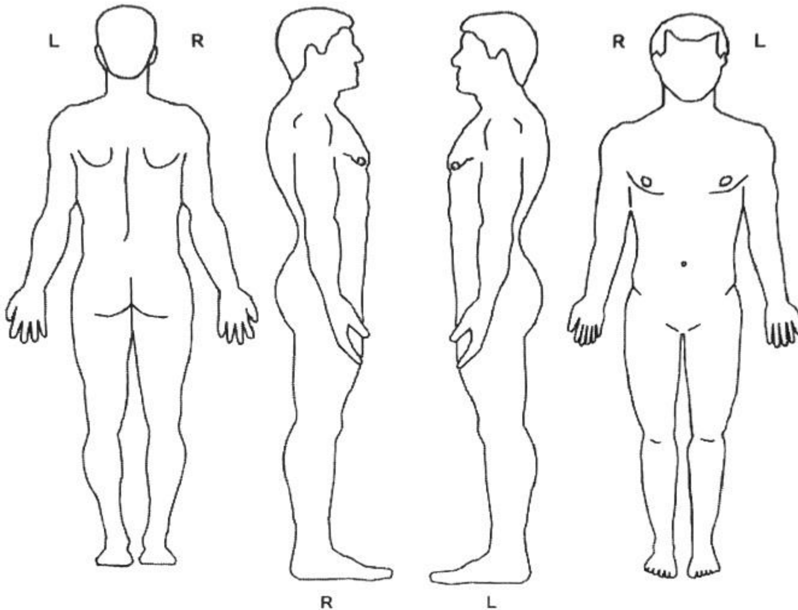
Is issue a result of: Car Accident   School/Work Related   Other ________

Have you seen any other doctor for this problem?   Yes   No   Dr. Name ____________

List any medications: ____________________

____

Are you   Left Handed / Right Handed



Doctor' Notes: ____________________

Have you had or have the following?

Symptoms or Problems	Constant or Frequent	Occasional
Pain:	____	____
Neck	____	____
Shoulder(s): Right Left Both	____	____
Arm/Hand: Right Left Both	____	____
Mid Back	____	____
Low Back	____	____
Hip/Sciatic: Right Left Both	____	____
Leg/foot: Right Left Both	____	____
Joints	____	____
Headaches or Migraines	____	____
Chest Pain	____	____
Joint Swelling	____	____
Muscle Spasms	____	____
Numbness/Tingling	____	____
Dizziness/Vertigo	____	____
Ringing in Ears	____	____
Cough	____	____
Flu/Fever	____	____
Weakness	____	____
Fatigue	____	____
Constipation	____	____
Diarrhea	____	____

Conditions	Constant or Frequent	Occasional
Insomnia	____	____
Anxiety	____	____
Depression	____	____
Blood Disorders	____	____
Kidney Problems	____	____
Epilepsy	____	____
Hearing Loss	____	____
Frequent Colds	____	____
Asthma	____	____
Allergies	____	____
Skin Conditions	____	____
	____	____

III. Childhood History (Prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

	Yes	No	Details
Did you have any childhood illnesses? (chicken pox, measles, etc.)	____	____	________________________________
Did you have any serious falls? (tree, seesaw, crib, etc.)	____	____	________________________________
Did/do you play sports?	____	____	________________________________
Did you have any surgeries?	____	____	________________________________
Prolonged use of medications? (antibiotics, inhalers, etc.)	____	____	________________________________
Any car accidents?	____	____	________________________________
Were you vaccinated?	____	____	________________________________
Were you under regular Chiropractic care?	____	____	________________________________
Do you :			
Carry a backpack in shool?	____	____	Average weight of backpack ______
Carry backpack on one shoulder or both?			________________________________
Drink water?	____	____	________________________________
Consume Caffeine?	____	____	________________________________
Consume vitamins or supplements?	____	____	________________________________

On a scale of 1 (being none) to 10 (being severe), rate your stress at: Home ________ School ________

On a scale of Poor, Good, Excellent, describe your:

Diet ________ Exercise ________ Sleep ____ General Health ________________

V. Wellness Commitment

At Lighthouse Chiropractic, we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this' we need to understand your commitment to being healthy. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

VI. Missed Appointment Policy

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.

In the instance of a no show, we reserve the right to charge you a $20.00 fee. Thank you for your understanding.

____

Parent/Guardian Name Parent/Guardian Signature Date

Insurance Information (if applicable)

Name of insured ________________________________

Date of Birth ________________________________

Insurance Company ________________________________

Phone # ________________________________

ID # ________________________________

Policy# ________________________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

____

Patient Name Patient Signature Date

____

Parent/Guardian Name Parent/Guardian Signature Date

Notice of Privacy Practices Acknowledgement
Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to

____
Patient Name (Please Print)

____ ____________________________
Patient Signature Date

OR

____
Signature of Personal Represent 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.

____
Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of recipt of our **Notice of Privacy**

___ An emergency prevented us from obtaining acknowledgment

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other: ____

____ ____________________________
Signature of Personal Representative Date