whole family CHIROPRACTIC

Inspiring a Health Revolution,
One Family at a Time

PEDIATRIC PATIENT APPLICATION FORM

DATE COMPLETED: ___/___/___

At Whole Family Chiropractic, we are committed to providing our pediatric patients with the care that will support healthy development in their first few years of life to set the stage for optimal health for the rest of their life. We are a very unique health care team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortions and injuries known to cause developmental and lifelong health problems.

As a result of this specialized approach we may not accept your child as a patient until we are absolutely certain that we know the cause of their condition, perform the necessary tests to determine the optimal program of correction, and we are completely confident that you and your child place their health as a top priority. At that time, we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

Please fill out the following information thoroughly so that your child's doctor can let you know whether their case can be accepted in our office. In the process, feel free to ask any questions if you need assistance.

Welcome to our clinic it is our pleasure to serve you and your children!

Dr. Ryan Dachowski, DC & Dr. Jessica Dachowski, DC, DICCP

PATIENT INFORMATION

Child's First Name:_____ **Initial**:__ **Last Name**:_____ (Age)____ Gender **M F**

Child's Home Address:_____ Home Phone: ( ) _____

City:_____State:_____Zip Code:_____ Child's Birth Date:____/____/____

Names of Siblings:_____ Ages:_____

Name of Mother/ Guardian: _____ Home Phone: ( ) _____

Birth Date:____/____/____ (Age)____ Marital Status **S M D W** Work Phone: ( ) _____

Home Address (if different):_____ Cell Phone: ( ) _____

How do you prefer to be contacted by the office: **Phone Cell Email**

City:_____State:_____Zip Code:_____ Email:_____

Mother Occupation:_____ Employer Name:_____

Name of Father/ Guardian: _____ Home Phone: ( ) _____

Birth Date:____/____/____ (Age)____ Marital Status **S M D W** Work Phone: ( ) _____

Home Address (if different):_____ Cell Phone: ( ) _____

How do you prefer to be contacted by the office: **Phone Cell Email**

City:_____State:_____Zip Code:_____ Email:_____

Father Occupation:_____ Employer Name:_____

REFERRAL INFORMATION

Who can we thank for referring your child to our office?

Doctor: _____ Friend: _____ Staff Member: _____

☐ Newspaper: _____ ☐ Internet: _____ ☐ Screening: _____ ☐ Signage ☐ Facebook/ Social Media ☐ Other:_____

PURPOSE OF THIS VISIT (*Please List Each of Your Child's Complaints Separately*):

Main Complaint # 1:

Reason for appointment/ Main complaint of your child:_____Date symptoms began: ____/____/____

Is this related to an Auto Accident / Injury/ Slip/Fall/ Birth Trauma ? **Yes No** If so, when: ____/____/____

How did your child's current problem or episode of pain/ discomfort occur?_____

Are the symptoms: **Constant Intermittent Activity-Related Progressively Worsening Off/On Sudden Chronic**

Do the symptoms interfere with: **School Sleep Hobbies/ Play Daily Routine Exercise** Are symptoms worsening? **Yes No**

Explain:_____

Is this the first time your child has had this problem/ pain? **Yes No** When did the 1st episode occur? _____

What activities aggravate their symptoms?_____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your child's pain over last 2 weeks:

Today _____ Best _____ Worst _____

Is there anything, which has relieved your child's symptoms? **Yes No** Describe:_____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when does your child feel this:_____

Does the pain radiate into their:___**Shoulder**____**Arm**___**Hand**___**Leg**___**Foot**___**Doesn't Radiate** Is it getting worse? **Yes No**

How often do they experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Who has your child seen for this?_____What did they do?_____

On a scale of **0** (*No Improvement*) **– 10** (*Full Improvement*) How did your child respond?_____

COMPLAINT # 2 (*If applicable*):

Additional reason(s) for today's visit:_____Date symptoms began: ____/____/____

Is this related to an Auto Accident / Injury/ Slip/Fall/ Birth Trauma ? **Yes No** If so, when: ____/____/____

How did your child's current problem or episode of pain/ discomfort occur?_____

Are the symptoms: **Constant Intermittent Activity-Related Progressively Worsening Off/On Sudden Chronic**

Do the symptoms interfere with: **School Sleep Hobbies/ Play Daily Routine Exercise** Are symptoms worsening? **Yes No**

Explain:_____

Is this the first time your child has had this problem/ pain? **Yes No** When did the 1st episode occur? _____

What activities aggravate their symptoms?_____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your child's pain over last 2 weeks:

Today _____ Best _____ Worst _____

Is there anything, which has relieved your child's symptoms? **Yes No** Describe:_____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when does your child feel this:_____

Does the pain radiate into their:**___Shoulder____Arm___Hand___Leg___Foot___Doesn't Radiate** Is it getting worse? **Yes No**

How often do they experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Who has your child seen for this?_____What did they do?_____

On a scale of **0** (*No Improvement*) **– 10** (*Full Improvement*) How did your child respond?_____

COMPLAINT #3 (*If applicable*):

Additional reason(s) for today's visit:_____Date symptoms began: ____/____/____

Is this related to an Auto Accident / Injury/ Slip/Fall/ Birth Trauma ? **Yes No** If so, when: ____/____/____

How did your child's current problem or episode of pain/ discomfort occur?_____

Are the symptoms: **Constant Intermittent Activity-Related Progressively Worsening Off/On Sudden Chronic**

Do the symptoms interfere with: **School Sleep Hobbies/ Play Daily Routine Exercise** Are symptoms worsening? **Yes No**

Explain:_____

Is this the first time your child has had this problem/ pain? **Yes No** When did the 1st episode occur? _____

What activities aggravate their symptoms?_____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your child's pain over last 2 weeks:

Today _____ Best _____ Worst _____

Is there anything, which has relieved your child's symptoms? **Yes No** Describe:_____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when does your child feel this:_____

Does the pain radiate into their:**___Shoulder____Arm___Hand___Leg___Foot___Doesn't Radiate** Is it getting worse? **Yes No**

How often do they experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Who has your child seen for this?_____What did they do?_____

On a scale of **0** (*No Improvement*) **– 10** (*Full Improvement*) How did your child respond?_____

GENERAL MEDICAL HISTORY

Who is your child's Primary Care Physician (PCP)?_____Specialty:_____

Last Visit Date: _____/_____/_____Reason for visit:_____ What did they do?_____

On a scale of **0** (*No Improvement*) **– 10** (*Full Improvement*) How did they respond?_____

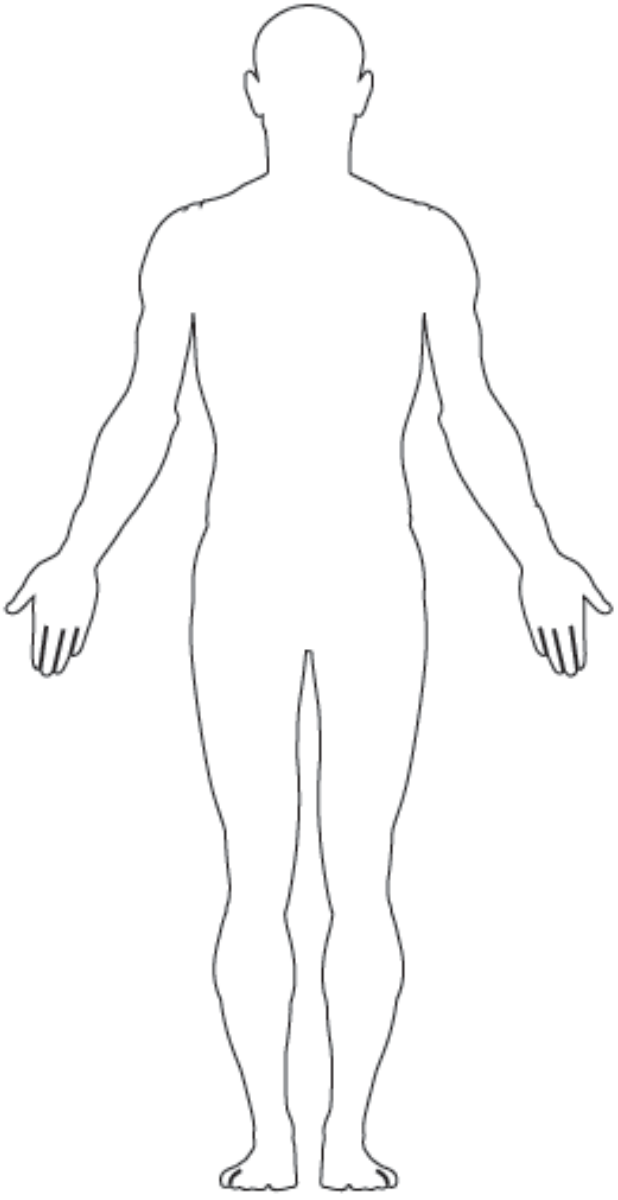
Has your child ever been to one of the following: Nutritionist_____ Homeopath/ Naturopath_____ Physical Therapist_____

Last Visit Date: _____/_____/_____Reason for visit:_____ What did they do?_____

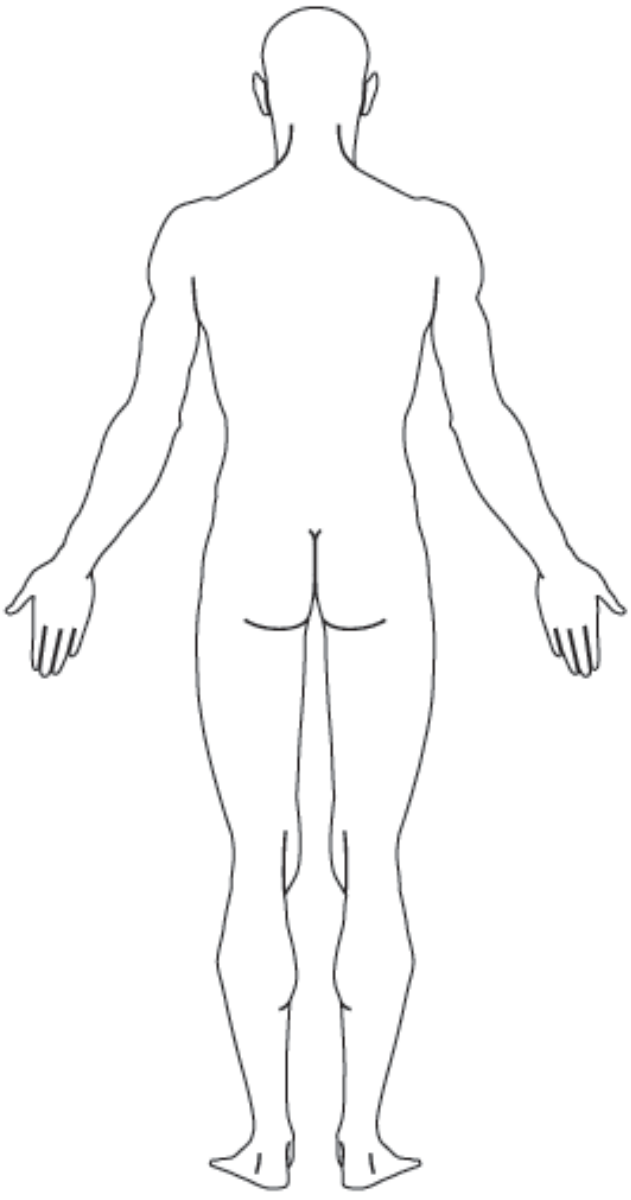
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms as it relates tot eh purpose of your visit today

A = ACHE	G = STABBING	N = NUMBNESS	R = THROBBING
B = BURNING	M = SPASMS	T = TINGLING	D = DULL
P = PINS & NEEDLES	F = STIFFNESS	S = SHOOTING	O = OTHER



FRONT



BACK

If you marked "O" for OTHER on any part, please explain below:

_____

_____

HEALTH CONDITIONS

Your child's spine is the foundation of their health and core strength in their body. Research demonstrates that shifts in the vertebra or regional displacements of the spine will spread and ultimately cause weakness and distortion to all of the areas of the spine. These distortions are reflected in abnormal posture positions. Evidence demonstrates that abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your child's condition and identify any associated risk factors.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebra, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections 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 a detailed explanation):

☐ Fell from a height of two (2) feet or more as an infant
☐ Were involved in an automobile collision
☐ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
☐ Difficult birth (see below)
☐ Rough shaking as an infant
☐ Experienced broken bones or debilitating injuries*

Explanation of (*) item(s):_____

BIRTH EXPERIENCE

Mother's Age at Delivery: _____yrs How long was the labor: _____# of Dental Amalgams (mom): _____
Prenatals/ Supplements During Pregnancy: **Yes** **No** Which:_____
Complications During Pregnancy: **Pre-Eclampsia** **Gestational Diabetes** **Placenta Previa/ Abruptia** **Toxemia**
Other Complications:_____
Mode of Delivery: **Vaginal/ No Drugs** **Vaginal w/Drugs** **C-section (Why:_____)**
Was Delivery Induced: **Yes** **No** Were Forceps or Vaccuum Extraction Procedures required?: **Yes** **No**
Was child: **Full-Term** **Premature** If premature, how many weeks:_____
Illnesses **During Pregnancy**:_____Medications **During Pregnancy**:_____
Vaccines **During Pregnancy**: _____Medications **During Labor/ Delivery**:_____
Medications administered **to child** after birth:_____

POSTNATAL HISTORY

Breast Fed? Yes No How Long?
Bottle Fed? Yes No Brand of Formula:_____ Began at What Age? _____ For How Long____
Foods? Yes No Begun at Age____ First Foods:_____
Milk? Yes No Begun at Age____ Non-Fat / 2% / Whole Raw Rice/ Almond/ Soy/ Coconut
Known Food Allergies:_____Suspected Food Sensitivities:_____

Top 3 Breakfast Foods	1._____	2. _____	3. _____
Top 3 Snacks	1._____	2. _____	3. _____
Top 3 Lunch Foods	1._____	2. _____	3. _____
Top 3 Drinks	1._____	2. _____	3. _____
Top 3 Dinner Foods	1._____	2. _____	3. _____

Check (X) for the most appropriate description of your child's diet:
_____Mostly Baby Foods _____Mostly Carbohydrate _____Mostly Dairy _____Mostly Vegetarian _____Other:_____

Please briefly describe your child's stool pattern (Daily, Foul, Large, Constipated, etc):_____

LIFESTYLE HISTORY

Does your child exercise? **Yes** **No** How often? **1x** **2x** **3x** **4x** **5x / per week** other:_____
What activities? Run/Jog Walk/ Hike Weight Train Bike Yoga/ Pilates Swim Dance Sports:_____
Does MOM/ DAD smoke? **Yes** **No** How much?_____
Does MOM/ DAD participate in Recreational/ Illegal Drug Use: **Yes** **No** Describe:_____

Does MOM/ DAD drink alcohol? **Yes** **No** How much / week?_____

Does MOM/ DAD drink coffee? **Yes** **No** How many cups / day? _____

VACCINATION HISTORY

What vaccinations has your child received (*Please note at what age and where received*):

1. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
2. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
3. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
4. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
5. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
6. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
7. _____ Age:_____ __ Mos. ___Yrs. Where received: _____
8. _____ Age:_____ __ Mos. ___Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (Please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

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

Explanation(s): _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following?
If so, please indicate (C) = Your child/patient, (O) = Other family member, next to all conditions or both if applicable

____ ADD/ ADHD
____ Arthritis
____ Broken Bones/ Fractures
____ Circulatory Problems
____ Ear Infections
____ Fetal Drug Exposure
____ Heart Disease
____ High Blood Pressure
____ Kidney Disease
____ Multiple Sclerosis
____ Neurologic Problems
____ Pneumonia/ Bronchitis
____ Scoliosis
____ Spina Bifida
____ Tuberculosis
____ Allergies/ Hay Fever
____ Asthma
____ Cancer
____ Crohn's Disease/ Colitis
____ Eczema/ Rash
____ Food Allergies
____ Heart Murmur
____ HIV
____ Liver Disease
____ Muscular Dystrophy
____ Osteoporosis
____ Polio
____ Sickle Cell Anemia
____ Stroke
____ Varicose Veins
____ Anemia
____ Bed Wetting
____ Cerebral Palsy
____ Depression
____ Psoriasis/ Lupus
____ Gall Bladder Problems
____ Lyme Disease
____ Infectious Disease
____ Lung Disease
____ Metal Implants
____ Paralysis
____ Fibromyalgia
____ Sudden Weight Gain/ Loss
____ Thyroid Problems
____ Whopping Cough
____ Appendectomy
____ Blood Sugar Problems
____ Chicken Pox/ Shingles
____ Diabetes
____ Epilepsy/ Seizures
____ Headaches
____ Hernia
____ Influenzae
____ Measles/ Mumps
____ Migraines
____ Pleurisy
____ Rheumatic Fever
____ Stress
____ Tonsillectomy
____ Other (Please Explain)

EXPERIENCE WITH CHIROPRACTIC

Has your child seen a chiropractor before? Yes No Who?_____When?_____

Reason for visits:_____How long was your child treated?_____

On a scale of **0** (*No Improvement*) **– 10** (*Full Improvement*) How did your child respond?_____

Did your child's previous chiropractor perform "Before **and After**" X-Rays? **Yes** **No** Only "**Before**" X-Rays No X-rays

Are you aware that your child's posture determines their overall health or were you ever told that it can? **Yes** **No**

Are you aware of any poor posture habits in your child or did they make you aware of any? **Yes** **No**

Explain:_____

The most common postural weakness is **FORWARD HEAD SYNDROME** (head and neck starting to bend forward progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your

child's overall health. **Have you ever been told, that your child carries their head forward, has a rounding of their shoulders, or is developing a "hump" at the base of their neck? Yes No**

HEALTH REVIEW OF YOUR CHILD'S BODY SYSTEMS (Check all that Apply)

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebra in your child's spine. When these spinal bones are twisted or shifted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. **These misalignments are called SUBLUXATIONS** (sub-lux-a-shuns). **It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your child's organs and overall health.** The most common and detrimental postural distortion is called FORWARD HEAD SYNDROME (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your child's neck will weaken the nerves in their arms, hands, and organs of the head and neck for example, thereby affecting these parts of their body.

Please indicate (N) = Now, (P) = Past, next to all conditions your child has experienced or both if applicable

____ Neck Pain / Pain in Head/ Face
____ Pain into child's Shoulders/ Arms/ Hands
____ Numbness/ Tingling in child's Shoulders/ Arms/ Hands
____ Coldness in child's Shoulders/ Arms/ Hands
____ Weakness in child's Shoulders/ Arms/ Hands
____ Difficulty Nursing/ Latching
Autoimmune Disease/ Frequent Fever & Chills
____Hyperactivity/ ADHD/ ADD
____ Headaches/ Migraines
____ Dizziness/ Vertigo
____ Visual Disturbances
____ Hearing Disturbances
____ Hyper/ Hypothryoidism
____ Colic/ Extreme Crying
Sore Throats
____ Frequent Nose Bleeds
____ Sinus Conditions/ Ear Infections
____ Allergies/ Hay Fever
____ Recurrent Colds/ Flu
____ Low Energy/ Fatigue
____ TMJ Pain/Clicking
____ Difficulty Sleeping/ Insomnia
Learning Disabilities
____ Other (Please Explain)

Explain:_____

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your child's upper back will weaken the nerves to their upper back, heart, lungs, and thyroid for example, thereby affecting these parts of their body.

Please indicate (N) = Now, (P) = Past, next to all conditions your child has experienced or both if applicable

____ Upper Back Pain
____ Heart Murmurs/ Palpitations
____ Tachycardia (Faster Heartbeat)
____ Gallstones/ Gallbladder Condition
____ Other (Please Explain)
____ Recurrent Lung Infections/ Bronchitis
____ Asthma/ Wheezing
____ Pain on deep Inspiration/ Expiration
____ High Cholesterol/ Blood Pressure
____ Chest Pain
____ Shortness of Breath
____ Scoliosis
____ Eczema, Skin Infections/ Rashes

Explain:_____

THORACIC SPINE (MID BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your child's mid-back will weaken the nerves to their pancreas, spleen, intestine, and kidneys for example, thereby affecting these parts of their body.

Please indicate (N) = Now, (P) = Past, next to all conditions your child has experienced or both if applicable

____ Mid-back Pain/ Pain between Shoulders
____ Pain into child's Ribs/ Chest
____ Indigestion/ Heartburn
____ Nausea/ Abdominal Cramping
____ Spleen/ Liver Problems
____ Hypo/Hyperglycemia (Low/ High Blood Sugar)
____ Lactose Intolerant
____ Irritable Bowel Syndrome/ Crohn's Disease/ Celiac Disease
____ Tired/ Irritable after eating when you haven't eaten for awhile
____ Other (Please Explain)
____ Diabetes I / II
____ Obesity
____ Ulcers/ Gastritis
____ Shingles

Explain:_____

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your child's lower back will weaken the nerves to their bladder, colon, reproductive organs, low back, hips, legs, and feet for example thereby affecting these parts of their body.

Please indicate (N) = Now, (P) = Past, next to all conditions your child has experienced or both if applicable

____ Low Back Pain
____ Numbness in child's Hips/ Legs/ Feet
____ Coldness in child's Hips/ Legs/ Feet
____ Muscle Cramps in Hips/ Legs/ Feet
____ Recurrent Bladder Infections
____ Difficulty/ Pain with Urination
____ Pain into child's Hips, Legs, Feet
____ Increased Gas/ Bloating
____ Bedwetting
____ Constipation/ Diarrhea
____ Restless Leg Syndrome
____ Menstrual Irregularities/ Cramping / Pain

____ Pain with Bowel Movement ____ Abdominal Pain/ Cramping ____ Other (Please Explain)
____ Weakness/ Injuries in child's Hips/ Legs/ Feet

Explain:_____

SURGERIES, TRAUMAS, MEDICATIONS, ALLERGIES:

Please list all **Past Surgeries** performed on your child:
Name of Surgery:_____**Date: ___/___/___ Dr:**_____
Name of Surgery:_____**Date: ___/___/___ Dr:**_____
Name of Surgery:_____**Date: ___/___/___ Dr:**_____

Please list all **Previous Accidents/ Falls/ Motor Vehicle Collisions** incurred by your child:
Incident:_____**Date: ___/___/___ Injury:**_____
Incident:_____**Date: ___/___/___ Injury:**_____
Incident:_____**Date: ___/___/___ Injury:**_____

Please list all **Medications** prescribed to your child**:**
Name:_____**Date Started: ___/___/___ Use:**_____
Name:_____**Date Started: ___/___/___ Use:**_____
Name:_____**Date Started: ___/___/___ Use:**_____

Please circle all **Allergies** diagnosed in your child**:**

FOOD PETS INSECTS MEDICATIONS ENVIORNMENT OTHER Describe:_____

ADDITIONAL INFORMATION:

Please list any symptoms that you would like your doctor to know about your child:

_____
_____
_____
_____

Please list any other history, pertinent thoughts or questions that you want addressed by your doctor:

_____
_____
_____

TERMS OF ACCEPTANCE:

When a person seeks chiropractic and rehabilitation health care services and is accepted for such care, it is essential for both parties to be working towards the same objective. **As a Chiropractic & Physical Medicine Rehabilitation Facility we have one main goal; to detect and correct/ reduce the vertebral subluxations complex.** It is important that each person understand both the objective and the method that will be used to attain this goal. 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 is by specific adjustment of the spine.

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

VERTERBAL 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 it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxations. Regardless of what a 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 and ability to heal. Our only method is the specific adjustment to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed that the amount paid to Whole Family Chiropractic for X-Ray, is for examination only and that the X-Rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

AUTHORIZATION OF CARE TO EVALUATE AND TREAT A MINOR/ CHILD:

I have read and fully understand the terms of acceptance and do hereby authorize and grant permission to the doctors of Whole Family Chiropractic and any designated staff members working under their supervision and instruction, to administer such care that is necessary for my child's spine and for their particular case/ condition. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy, rehabilitative exercises, passive therapy, diagnostic X-Rays and non-chiropractic procedures including; nutritional intervention, and lifestyle management or any other intervention that is advisable and necessary for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function and overall improvement of my child's health.

I have had an opportunity to discuss with the doctor of chiropractic assigned to my child and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my child's health care. **I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.** 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 and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk 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 child's best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

Lastly, I clearly understand that if I do not follow the doctor's specific recommendations for my child at this clinic, that my child will not receive the full benefit of the programs offered. Additionally, I recognize that if I terminate the recommended care plan for my child prematurely, then all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the doctor for all services rendered to my child. I also understand that any sum of money paid under assignment by any insurance company shall be credited to my child's account, and I shall be personally liable for any and all of the unpaid balance to the doctor as the responsible party to my child's account.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by singing below I agree to the above-named procedures for my child. I intend this consent form to cover the entire course of my child's treatment for their present condition and for any future condition(s) for which I seek treatment for them.

(*If under 18*) Parent's / Legal Guardian Signature:_____ Date: ____/ ____/ ____

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an X-Ray evaluation. I have been advised that X-Ray may be hazardous to an unborn child.

Date of Last Menstrual Cycle: _____/_____/_____ _____ ____/____/____

Signature (Parent if Minor) *Date*

CONSENT TO X-RAY:

I hereby grant Whole Family Chiropractic, L.L.C. permission to perform an X-Ray evaluation if determined to be medically necessary for:_____. **I understand that X-Rays are being performed to locate vertebral subluxations, and not to diagnose or treat and other disease or condition.**

(*If under 18*) Parent's / Legal Guardian Signature:_____ Date: ____/ ____/ ____

INSURANCE INFORMATION:

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the Explanation of Benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic, and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your service for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will automatically be transferred to your credit card or the extended payment plan.

Note: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the services you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION:

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. **The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.** Any monies received will be credited to my account. I certify (for personal insurance purposes only) that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and/or finalized.

Signature of Person Authorizing Care/ Payment: _____ ____/____/____

Signature (Parent if Minor) *Date*

ACCOUNT RESPONSIBLE INFORMATION

First Name:_____M. Initial:__ Last Name:_____ (Age)____ Gender **M** **F**

Home Address:_____ Home Phone: ( ) _____

City, State, Zip:_____ Work Phone: ( ) _____

Email Address:_____ Cell Phone: ( ) _____

Birth Date:_____/_____/_____ Social Security #: _____-_____-_____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name:_____Policy#:_____

Carrier Address:_____City, State, Zip:_____
Insured Person First Name:_____M. Initial:__ Last Name:_____
Relationship to Insured:_____Home Address: _____ Home Phone: ( ) _____
City, State, Zip:_____ Work Phone: ( ) _____
Email Address:_____ Cell Phone: ( ) _____
Insured Birth Date:_____/_____/_____ Social Security #: _____-_____-_____ Gender: M F
Insurance ID #:_____ Group #:_____ Group Name:_____

RAND 36 GENERAL HEALTH SURVEY

1. In general, would you say your health is: (**Circle one number**)	Excellent	1
	Very Good	2
	Good	3
	Fair	4
	Poor	5
2. **Compared to one year ago**, how would you rate your: general health **right now**?	Much better than one year ago	1
	Somewhat better than one year ago	2
	About the same	3
	Somewhat worse now than one year ago	4
	Much worse now than one year ago	5

The following questions are about activities that you might perform on a typical day.
Does **your health now limit you** in these activities? If so, how much?

(Circle one Number on each line)	**Yes Limited a Lot**	**Yes Limited A Little**	**No Not Limited**
3. **Vigorous Activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate Activities**, such as moving a table, pushing a vacuum, bowling, or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling, or stooping	1	2	3
9. Walking **more than one mile**	1	2	3
10. Walking **several** blocks	1	2	3
11. Walking **one** block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? **(Circle one number on each line)**

	Yes	**No**
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems**? **(Circle one number on each line)**

	Yes	**No**
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health, or emotional	Not at All	1

problems interfered with your normal social activities with family, friends, neighbors, or groups? **(Circle one number)**	Slightly	2
	Moderate	3
	Quite a bit	4
	Good	5
21. How much bodily pain have you had during the **past 4 weeks**: **(Circle one number)**	None	1
	Very Mild	2
	Mild	3
	Moderate	4
	Severe	5
	Very Severe	6
22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework) ? **(Circle one number)**	Not at all	1
	Slightly	2
	Moderately	3
	Quite a bit	4
	Extremely	5

These questions are about how you feel and how things have been with you **during the past 4 weeks**.
For each question, please give the one answer that comes closest to the way that you have been feeling.
How much of the time during the **past 4 weeks**:
(Circle one number on each line)

	ALL of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Do you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc? **(Circle one number)**	All of the time	1
	Most of the time	2
	Some of the time	3
	A little of the time	4
	None of the time	5

How **TRUE** or **FALSE** is each of the following statements for you?
(Circle one number on each line)

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5