CHIROPRACTIC REGISTRATION & HISTORY - CHILD

Portsmouth Family Chiropractic ♦ Orchard Park ♦ 875 Greenland Road ♦ Suite B-1 ♦ Portsmouth, NH 03801
Ph 603.427.1100 ♦ Fax 603.427.5595

1. PATIENT INFORMATION

Name _____ MI _____
Address _____
City _____ _____ St _____ Zip _____

Birth Date _____/_____/_____ Age _____ Grade _____
SS# _____-_____-_____ Male ☐ Female ☐

Siblings? Yes ☐ No ☐ How Many? _____ Ages _____

School Name _____

Who is the primary adult contact & guarantor for this child?
_____

Home Phone (_____) _____ - _____
Best time to reach you? _____ AM ☐ PM ☐

Email _____

Whom may we thank for referring you?
_____

2. CONTACT INFORMATION

Mother's Name _____
Address _____
City _____ St _____ Zip _____
Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____ Ext _____
Other Phone (_____) _____ - _____

Are Parents Married ☐ Separated ☐
Divorced ☐ Other ☐

Father's Name _____
Address _____
City _____ St _____ Zip _____
Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____ Ext _____
Other Phone (_____) _____ - _____

In case of emergency, please contact:
Name _____
Daytime phone (_____) _____ - _____

3. PATIENT CONDITION

Reason for visit or primary complaint? _____
_____

When did your child's symptoms first appear? _____ Immediate onset ☐ Gradual onset ☐

Can you recall an event/activity that caused the onset of symptoms? Yes ☐ No ☐ If yes, please describe: _____
_____

Is your child's condition due to an accident? Yes ☐ No ☐ If yes, please provide date: _____ / _____ / _____

Type of accident: Auto ☐ Sports ☐ Home ☐ Other ☐ _____

Is your child's condition or health getting progressively worse? Yes ☐ No ☐ Not Sure ☐

Rate the severity of your child's pain on a scale from 1 (least pain) to 10 (severe pain) _____

What is your child's overall level of physical energy? Energetic ☐ Normal ☐ Fatigued ☐ Other _____

Describe any pain or discomfort (check all that apply):	These conditions affect:	Difficult movements:	Exercise / Sports:
☐ Sharp ☐ Burning ☐ Throbbing ☐ Cramping ☐ Numbness ☐ Stiffness ☐ Shooting ☐ Swelling ☐ Aching ☐ _____	☐ School ☐ Daily Routine ☐ Sleep ☐ Recreation ☐ Relationships ☐ _____	☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ _____	☐ None ☐ Occasional ☐ Weekly ☐ Daily ☐ Heavy / Competitive ☐ _____

4. HEALTH HISTORY

What treatment has your child already received for his/her condition? (check all that apply)

- ☐ Prescription medications
- ☐ Over-the-counter medications
- ☐ Surgery
- ☐ Physical Therapy
- ☐ Massage
- ☐ Acupuncture
- ☐ Homeopathy
- ☐ Herbal Therapies
- ☐ Chiropractic Services (Chiro Name _____)
- ☐ Other _____

Type of birth delivery? ☐ Natural ☐ C-Section ☐ Other _____

Check the box for any/all categories that apply to your child's past or current situation.

- ☐ Accident Prone
- ☐ Acne
- ☐ ADD
- ☐ ADHD or Hyperactivity
- ☐ Allergy, Food
- ☐ Allergy, Other
- ☐ Allergy Shots
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Childhood Immunizations
- ☐ Colic
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Eczema
- ☐ Ear Infections
- ☐ Ear Tubes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Fractures
- ☐ Hepatitis
- ☐ Headaches
- ☐ Headaches, Migraines
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Physical Abuse
- ☐ Polio
- ☐ Runny Nose
- ☐ Scoliosis
- ☐ Seborrhea
- ☐ Skin Disorder
- ☐ Speech Problems
- ☐ Tumors/Growths
- ☐ Other (please list)

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/SUPPLEMENTS

TRAUMA or INJURY
Description / Reason

Category		Date
Falls / Accidents		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

5. FINANCIAL UNDERSTANDING

Insurance Providers / Third Party Contracts

We recognize that many of our patients participate in group health insurance plans, including Medicare. Some may even be seeking care based on an accident or injury and are contracting with an attorney or Workman's Compensation. Our professional services, however, are charged to the patient receiving care and his/her guardian, not the insurance provider or third party. At the close of each visit, we will supply you with a detailed patient statement that should satisfy your insurance documentation requirements. By eliminating insurance interactions, we are able to keep our business office streamlined, maintain lower costs and provide you with the best Chiropractic healthcare, without disruption or negotiation.

In the event a dispute arises between you and your provider, we will do our best to provide you with reports or documentation that may be helpful in receiving any reimbursement you are entitled. We will not become involved in discussions with your insurance company regarding deductibles, co-pays, covered charges, diagnostic codes, secondary insurance, "usual and customary" charges, etc., other than to reply to factual information.

Forms of Payment

Patient's guardians are responsible for full payment at the time of service. To make this easy for you, we accept Mastercard, Visa, American Express, Discover and Debit cards, as well as personal checks and cash. We believe that Upper Cervical Care dramatically changes the lives of our patients. If your inability to pay our fees is affecting your decision to obtain care, please let us know and we'll discuss options that are available to you.

Thanks for your understanding, but most of all – thanks for giving us an opportunity to serve you !

Signature _____ Date _____ / _____ / _____ Patient Comments _____

TERMS OF ACCEPTANCE FOR CARE

Chiropractic care seeks to improve health through natural means, without drugs or surgery. The primary goal is to remove nerve interference by correcting subluxations and allowing the body to function at its best – this includes the body's innate ability to heal itself. In order to prevent any confusion or misunderstanding, it's important that you understand the objective and method used to obtain this goal.

TREATMENT

Our method for correcting the spine is specific Upper Cervical Chiropractic adjusting. These procedures are non-force, scientifically researched, safe and effective. We do not diagnose or treat disease other than subluxations. We may recommend lifestyle changes or nutritional programs that benefit certain conditions. However, if during the course of Chiropractic examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you wish to pursue further treatment for those findings, we will recommend another health care provider.

INSURANCE/THIRD PARTY PAYERS

Many patients participate in group health insurance plans, including Medicare. Some have been involved in an accident or injury and are contracting with an attorney or Workman's Compensation. Our professional services, however, are charged directly to the patient receiving care, and not the third party. At the close of each visit, we will supply a detailed statement that should satisfy your insurance filing requirements. By eliminating insurance interactions, we are able to keep our business office streamlined, maintain lower costs, and provide you with the best Chiropractic healthcare – without disruption or negotiation.

We will do our best to provide you with reports or documentation that may be helpful in receiving reimbursement you are entitled. It is not customary for us to become involved in discussions with your insurance carrier regarding deductibles, co-payments, covered charges, diagnostic codes, secondary insurance, legal claims, "usual & customary" charges, etc., other than to reply to factual information.

PAYMENT

Patients are responsible for full payment at the time of service, unless arrangements are made in advance. We accept Mastercard, Visa, Discover, American Express, debit cards, as well as personal checks and cash. Additional charges will be assessed for returned checks, missed appointments, missed payments and copying records.

Are you signing this Acceptance as a parent or legal guardian of a minor? YES ☐ NO ☐
Name of Child: _____ Age _____

Please read and initial each statement:

1. _____ I authorize the Doctor and/or associates to perform Chiropractic exams, adjustments and procedures, including diagnostic x-rays for detecting and correcting body imbalance and subluxations of the spine.
    a. ☐ I am not pregnant. My last menstruation started ____/____/____.
    b. ☐ My child is not pregnant. Her last menstruation started ____/____/____.
2. _____ I authorize the Doctor and/or associates to exchange information or release office records to process insurance claims.

I have read the above statements regarding services, treatment and finances. I understand the Doctor's objectives pertaining to my/my child's care in this office.

_____ _____
signature date

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