Infant--5 years old

Name: _____ Age:_____

Address: _____ City:_____ State:_____Zip:_____

Phone #: _____ Date of Birth: _____ ☐Male ☐Female

Mother's Name: _____ Father's Name: _____

Reason for consulting our office: _____

Whom may we thank for referring you? _____

Please circle one if you would like to be sent a reminder for future appointments: Text Email

If you selected Email please list one: _____

Health Profile

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our first goal is to address the issues that brought you to this office. Our second goal is to offer you and your child the opportunity of improved health potential and wellness services.

Does your child have any symptoms or complaint? ☐ Y ☐ N

Are you here for a wellness visit? ☐ Y ☐ N

Please describe symptoms and complaint if you circled yes. Also, please describe any effects it is having on your child. _____

If the child is experiencing pain, is it: ☐Sharp ☐Dull ☐Comes and goes ☐Travels ☐Constant

Since the problem started, is it: ☐About the same ☐Better ☐Worse

It interferes with: ☐School ☐Sleep ☐Walking ☐Sitting ☐Hobbies

☐ Other: _____

Other doctors seen for this problem? (M.D., Chiropractor, etc.) _____

List any medications the child is taking or surgeries the child has had:

_____

CROSSROADS CHIROPRACTIC

Daily we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most time the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy

Were there any complications to the pregnancy? ☐ Y ☐ N _____

Was mom on any medications, prescription or over-the-counter? ☐ Y ☐ N

Did mom or dad smoke during the pregnancy? ☐ Y ☐ N Who? _____

Was the baby ever in a breech position? ☐ Y ☐ N How many ultrasounds were performed? _____

Birth

Where was the baby born? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

Was the delivery: ☐ Vaginal ☐ C-section

Were there any devices used? ☐ Y ☐ N ☐ Forceps ☐ Vacuum

How long was the labor? _____ How long was the delivery? _____

Was the oxytocin/Pitocin used? ☐ Y ☐ N Was an epidural administered? ☐ Y ☐ N

Infancy

Was the infant vaccinated? ☐ Y ☐ N If yes, is child: ☐ Partially ☐ Delayed ☐ Fully

Was there any prolonged use of medicines or an inhaler? ☐ Y ☐ N If yes, which? _____

Did the infant suffer any traumas or serious falls or car accidents? ☐ Y ☐ N

Has the infant been under regular chiropractic care? ☐ Y ☐ N

Childhood

Did the child have any childhood disease? ☐ Y ☐ N Explain_____

Does the child play sports? ☐ Y ☐ N Which? _____

Has the child suffered any emotional traumas? ☐ Y ☐ N

Please give us any other information you feel would be helpful:

_____

The statements made on this page are accurate to the best of my recollection and I request and give consent to Dr. Lindsey Rovenstine giving a chiropractic examination and treatment to my child.

X Parent's signature _____Date:_____

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **CROSSROADS CHIROPRACTIC** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I understand that a copy of the Notice of Patient Privacy Policy is available upon request and I can request this at any time.

X _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Occasionally we have an open treatment area, but upon notification private areas are available.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

X _____ _____

Patient or Legally Authorized Individual Signature — Date

X _____ _____

Print Patient's Full Name — Time

_____ _____

Witness Signature — Date

Appointment Cancellation Policy

We strive to render excellent care to you and the rest of our patients. Your care and treatment are a priority to us. We also ask that you respect our physician's time and expertise as well. In an attempt to be consistent with this, we have an appointment cancellation policy that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor's time.

Our policy is as follows:
We request that you give 24-hour notice in the event that you cannot make it to your scheduled appointment. If you miss an appointment without contacting our office or reschedule or cancel an appointment with less than 24-hour notice, it is considered a "missed" or "no show" appointment. YOU WILL BE CHARGED $25.00 FOR THE VISIT YOU WERE SCHDULED FOR. In order to make another appointment you will need to settle your account prior to your next visit or for both visits prior to leaving your next adjustment. Additionally, if you are more than 10 minutes late for an appointment, it will be considered a "missed" or "no show" appointment, and that appointment will need to be rescheduled. Also, if you miss more than 3 appointments, Crossroads Chiropractic reserves the right to discharge you from the practice for failing to follow treatment recommendations.

You may contact the office via phone or email. Phone is preferred. Please see our business card with all the contact information.

If you have any questions regarding this policy, please let our staff know, and we will be happy to clarify the policy for you.

We look forward to being a continued part of your wellness.

I have read and understand the Appointment Cancellation Policy of Crossroads Chiropractic and I agree to be bound by its terms. I am aware that I must pay for missed appointments prior to making a new appointment or as otherwise worked out by staff.

X _____ _____

Patient or Legally Authorized Individual Signature — Date

X _____

Print Patient's Full Name

_____ _____

Witness Signature — Date


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