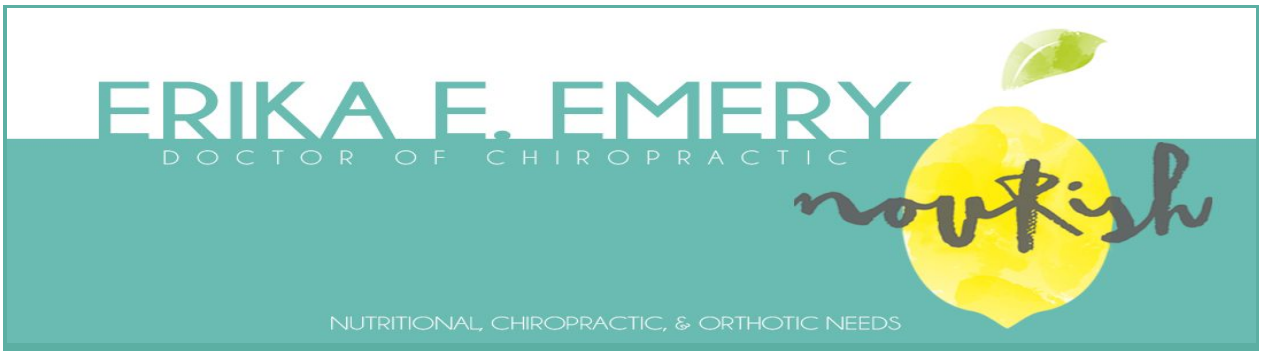


Date: _____

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Email: _____

Birth Date: _____ Age: _____ Sex: M F

Number Of Siblings: _____

Siblings(s) Names & Age: _____

Parents' Name:_____

Best Contact Name:_____ Phone: ( ) _____

Alternate Contact Name: _____ Phone: ( ) _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Nourish Chiropractic?

_____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

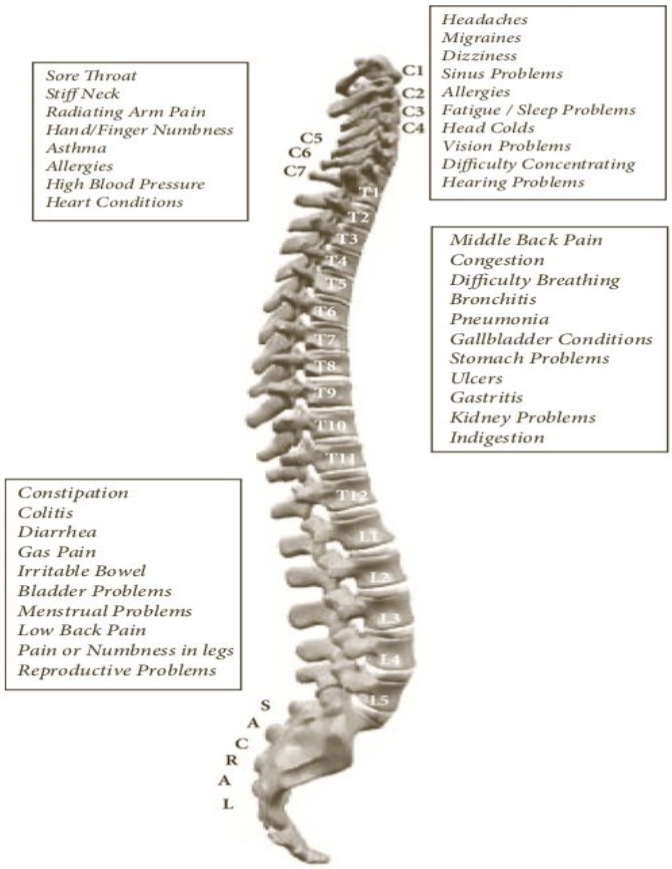
_____

_____

HEALTH CONCERNS

- ❑ Anxiety/Depression
- ❑ Constipation/Diarrhea
- ❑ Nausea/Vomiting
- ❑ Diabetes
- ❑ Bed Wetting
- ❑ Overweight
- ❑ Frequent sickness
- ❑ ADD/ADHD
- ❑ Irritability/Nervous
- ❑ Development Delay
- ❑ Fatigue/Sleep issues
- ❑ Asthma/Chronic Bronchitis
- ❑ Colic/Acid Reflux
- ❑ Back/Neck Pain/Stiffness
- ❑ Difficulty Gaining Weight
- ❑ Frequent Ear Infections
- ❑ Headaches
- ❑ Learning Disorder
- ❑ Sinus Troubles/Allergies
- ❑ Autism/Asperger's/Sensory Issues
- ❑ Other: _____

Explain any boxes checked above or add additional concerns:



_____
_____
_____
_____

Is there anything else regarding your child's current condition you feel the doctor should know?_____
_____
_____

MEDICATIONS

- ❑ Anxiety/Depression
- ❑ Asthma
- ❑ Pain Narcotics
- ❑ Antibiotics
- ❑ Migraine/Headache
- ❑ Acid Reflux
- ❑ ADD/ADHD
- ❑ Digestive
- ❑ Other _____

- ❑ Other _____

- ❑ Other _____

Explain any boxes checked above: _____

_____

VITAMINS/SUPPLEMENTS

- ❑ Multi-Vitamin
- ❑ Vitamin D3
- ❑ Fish Oil/Omega-3
- ❑ Probiotics
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Explain any boxes checked above:

_____

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery: ☐C-section delivery ☐ Doctor pulled or twisted baby ☐ Anesthesia ☐ Labor was induced ☐ Forceps/vacuum extraction ☐ Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain:_____

_____ Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____ Ultrasound used during pregnancy? Yes No Number of times: _____ Did /do you breastfeed the baby? Yes No If yes, how long: _____ Did/do you formula-feed the baby? Yes No If yes, how long: _____ At what age did you introduce: Solids:_____ Cow's milk:_____

LIFESTYLE HABITS

Does your child..... **Exercise daily?** Yes No How much? _____ **Have a positive self-esteem or self-image?** Yes No **Play video games or watch TV for more than one hour per day?** Yes No How much? _____ **Eat balanced meals?** Yes No **Experience prolonged sadness?** Yes No Explain:_____ **Have difficulty sleeping?** Yes No Explain:_____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No Explain: _____ Has your child ever been hospitalized or had surgery? Yes No Explain:_____ Does your child have difficulty interacting with others? Yes No Explain:_____ Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No Explain: _____

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No Please list:

_____

Are you aware of any food allergies or intolerance? Yes No Explain:

_____ Has your child received all recommended vaccinations?

Yes No Explain: _____ Please rate stress levels on a scale of 1-10 (10 being highest) School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Nourish Chiropractic permission to examine, x-ray (if necessary), and treat _____

Minor date of birth: _____

Parent/Guardian Signature: _____

Date: _____

Witness Signature: _____

X-RAY CONSENT

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which Nourish Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed:_____ Date:_____

For Office Use Only

ID#_____

Films:_____

ROF:_____

Other:_____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, pubic health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. *I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.*

Date:_____ Print Patient Name:_____

Signature:_____

AUTHORIZATION FOR CARE

I hereby authorize the doctor and staff at Nourish Chiropractic to treat my condition as deemed. At Nourish Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any staff member of Nourish Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you. Date: _____

Signature: _____

ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: _____

Name(Printed):_____

Signature:_____

Parent/Guardian Signature (if applicable): _____