Child's Last Name: _____ First: _____ Sex: M / F , Birth Date: ___/___/___

Parents Name: _____ Today's Date ____/____/____

Who may we Thank for referring you to our office? _____

Your Child's Health Profile

Why This Form Is Important

As a traditional (wellness) Chiropractic office, we focus on your ability to be healthy. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Children are very sensitive to the stress parents have and this causes stress in them. Most times the effects are gradual not even seen until they become serious. Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Answering the following questions will give us a profile of the specific stresses your child has faced, allowing us to better assess the challenges to your child's health potential.

If your child has no symptoms or complaints and are here for wellness services, please check (√) here ☐ Others need to describe the major complaints, how and when did it start? Including the effect it has had on you and your child's life.

Please rate 0-10 with 10 being the worst.

1. _____ 0-10 = _____

2. _____ 0-10 = _____

3. _____ 0-10 = _____

4. _____ 0-10 = _____

What makes it better: 1 _____ 2 _____

3 _____ 4 _____

What makes it worse: 1 _____ 2 _____

3 _____ 4 _____

Previous Chiropractic care _____ Date of last visit ___/___/___ Reason: _____

Name of Pediatrician: _____ Date of last visit ___/___/___ Reason: _____

Number of Doses of Antibiotics Your Child Has Taken: _____ List: _____

Number of Doses of Prescription Medication Your Child Has Taken: _____ List: _____

Number of Doses of Non-Prescription Medication Your Child Has Taken: _____ List: _____

Current Medications: _____ Vitamines/Supplyments: _____

Hospital/Emergency Room visits: _____ Prior Surgery: _____

Other Doctors Seen for this Condition ☐NO ☐YES. Doctors' Names and Prior Treatment: _____

Other Health Problems: _____

PRENATAL HISTORY: Complications During Pregnancy: Toxemia Diabetes Morning Sickness ☐Heartburn ☐Back Pain ☐Headaches ☐Other, **Mothers' Health/Nutrition** ☐Poor Good Excellent, **Stress During Pregnancy:** Please rate 0-10 with 10 being the most _____

Family History Of: Diabetes, Heart/Cardiovascular Problems, Other anomalies: _____

Falls/Injuries/Accidents During Pregnancy: _____ Complication During Delivery: ☐No ☐Yes, ☐C-Section ☐Vacuum/Forceps ☐Induced ☐Epidural ☐Fetal distress ☐Meconium, **Oxygen** ☐no ☐yes _____ **ICU** ☐no ☐yes ___

BIRTH INJURIES: Bumps/Bruises/Swelling _____ Broken Bones _____ Other _____

FEEDING HISTORY: Food/Juice Allergies or Intolerances: ☐No ☐Yes, List: _____

Do you have any concerns about your child's diet? _____

What does your child eat for breakfast? _____

What does your child eat for lunch? _____

What does your child eat for dinner? _____

What does your child eat for snacks? _____ Favorite food _____

What fast food does your child eat? _____ Times/week _____

How much water does your child drink _____cups/day, How much juice does your child drink _____cups/day,

How much soda pop does your child drink _____cups/day. # of bowel movements each day_____

Has your child fallen from a bike, skateboard, scooter, rollerblades or similar. ☐No ☐Yes Has your child fallen down stairs or from a height greater than 3 feet ☐No ☐Yes Has your child ever been in a motor vehicle accident or near-miss ☐No ☐Yes. Number of hours watching TV/day_____, Hours spent at the computer/video games /day_____, How heavy is their backpack/schoolbag____.

What sports/activities does the child do _____,

Vaccines: ☐No ☐Yes, ☐Partial ☐Complete **Reactions:** (Fever, Fussy, Ect.) ☐Slight ☐Mild ☐Severe

Describe reactions: _____,

Check any of the following that your child has suffered from: Falls _____ Car Accident _____

☐Ear Infections_____	Asthma_____	☐Bed Wetting_____
☐Digestive Difficulties_____	☐Recurrent Fevers_____	☐Frequent Colds_____
☐Seizures_____	☐Tremors_____	☐Sleep Problems_____
☐Allergies_____	Head Tilt_____	☐Feeding Difficulties_____
☐Rashes/ Dry skin_____	☐Foot/Hip/Leg Problems_____	☐Hand/Arm/Shoulder Problems_____
☐Difficulties Breathing_____	☐Growing Pains_____	☐Weight Loss/Poor Weight Gain_____
☐Constipation/Diarrhea_____	☐Spitting Up/Vomiting_____	Dislocated a Joint_____
☐Excessive Gas_____	☐Head Banging or Headaches_____	☐Broken/Fractured a Bone_____
☐Kidney/Bladder Problems_____	☐Heart Conditions_____	☐Hernias_____
☐Vision Problems_____	☐Hearing Problems_____	Co-ordination Problems_____
☐Postural Problems_____	☐Attention/Hyperactivity_____	☐Nightmares_____
☐Reading/ Learning Difficulties_____	☐Respiratory Infections_____	☐Trouble Walking /Running_____

The following 3 areas can contribute to nerve interference and malfunction and diminish quality of life. Circle the areas that apply to you r child: **Y=Yes N=No or Never had (please circle)**

Physical Stress			**Emotional Stress**			**Chemical Stress**		
Slip/Fall / Sport Injury	Y	N	Family	Y	N	Second Hand Smoke	Y	N
Poor Posture	Y	N	Hold Feelings In	Y	N	Sugar/Carbs/Sweeteners	Y	N
Lack of Physical Activity	Y	N	Quick Temper	Y	N	Poor Diet	Y	N

TERMS OF SERVICE When a person seeks chiropractic care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. We also strive to inform you how minimize or manage physical, chemical and emotional stress that creates the subluxations.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine and extremities.

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

VERTEBRAL 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 wisdom/ability to express its maximum health potential.

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 evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area. Regardless of what 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. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends, then welcome! You are in the right place.

I, (Printed name) _____ (Signature) _____ undertake chiropractic services on the understanding of and agreement with, the above explanation. _____ (Date)

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____ (Print name) give permission for my child to receive chiropractic care

Financial Policy

ASSIGNMENT OF BENEFITS

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Dr. Becky A. Grimm, D.C and/or Dr. Nicole Paxton, D.C.

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Not with standing denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

GEM CITY CHIROPRACTIC, LLC (GCC, LLC)

PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying GCC, LLC, in writing, except to the extent GCC, LLC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosure that GCC, LLC may use of your protected health information.

You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request GCC, LLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. GCC, LLC is not required to agree to requested restrictions. If GCC, LLC agrees to the requested restriction, GCC, LLC will honor the request and it will e binding on the office.

I hereby consent to the use and disclosure by Gem City Chiropractic, LLC, its workforce, and its business associated of my protected health information for the purpose of treatment, payment, and health care operations.

Signature Date

Guardian Signature Relation to Patient Date

FINANCIAL POLICY - GEM CITY CHIROPRACTIC. LLC

FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE - We request that 100% of the first visit and subsequent visits be paid at the time of the visit unless other arrangements have been pre- arranged and agreed upon. A payment plan can be established in writing.

GROUP OR INDIVIDUAL INSURANCE - When possible, we will call to verify benefits on you insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductible or co-pays.

"ON THE JOB" INJURY (Workers Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS - Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care in initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE - We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE - Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

INSURANCE ONE TIME AUTORIZATION

I understand that my insurance is an arrangement between myself and my insurance company. NOT between Dr. Grimm or Dr. Paxton and my insurance company. I request that Gem City Chiropractic, LLC prepare the customary forms at no charge so that my insurance company can process my claim(s). I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Becky A. Grimm, D.C and/or Dr. Nicole G. Paxton, D.C., that fees will be due and payable immediately.

Gem City Chiropractic, LLC.

Signature Date

Guardian Signature Relationship to Patient Date