

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 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 baby has faced, allowing us to better assess the challenges to your child's health potential.

If your child has no symptoms or complaints, and is here for wellness care, please check (✓) here ____ Others need to briefly describe the problem/difficulty your child is experiencing. 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: _____

What makes it worse: _____

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

Is the problem getting ☐ Better ☐ Same ☐ Worse Explain _____

Other Doctors seen for this condition? ☐ NO ☐ YES. Doctor's name and prior treatment: _____

Other health problems: _____

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: _____

Hospital/Emergency Room visits: _____ Prior Surgery: _____

PRENATAL HISTORY:

Complications During Pregnancy: ☐ Toxemia ☐ Diabetes ☐ Morning Sickness ☐ Heartburn ☐ Back Pain ☐ Headaches ☐ Other
Mother's 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: _____

Complications during delivery: ☐ NO ☐ YES, ☐ C-Section ☐ Vacuum/Forceps ☐ Induced ☐ Epidural ☐ Fetal Distress ☐ Meconium

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 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 spent watching TV/day _____. Hours spent at the computer or playing video games/day _____.

How heavy is their backpack/schoolbag? _____

What sports/activities does your child participate in? _____

VACCINES: ☐NO ☐YES ☐PARTIAL ☐COMPLETE **REACTIONS:** (Fever, fussy, etc.) ☐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 Joint _____

☐Excessive Gas _____ ☐Head banging/Headaches _____ ☐Broken/fractured bone _____

☐Kidney/Bladder problems _____ ☐Heart Conditions _____ ☐Hernias _____

☐Vision Problems _____ ☐Hearing Problems _____ ☐Co-Ordination Problems _____

☐Postural Problems _____ ☐Attention/Hyperactivity _____ ☐Nightmares _____

☐Reading/Learning difficult _____ ☐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 your 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
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Poor Posture	Y	N	Holding feelings in	Y	N	Sugar/Carbs/Sweeteners	Y	N
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Lack of Physical Activity	Y	N	Quick Temper	Y	N	Poor Diet	Y	N
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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 to minimize or manage physical, chemical and emotional stress that creates the subluxations.

ADJUSTMENT: An adjustment is the specific application of force 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 the 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, (print 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- Gem City Chiropractic L.L.C.

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 and subsequent visits be paid in full at the time of the visit unless other arrangements have been made and agreed upon. A payment plan can be established in writing.

GROUP OR INDIVIDUAL INSURANCE- When possible we will call to verify benefits on your 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-pay.

“ON THE JOB” INJURY/ WORK COMP- 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 insurance carrier. 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 AUTO ACCIDENT- Please notify your auto insurance carrier of your visit to our office immediately. Notify your insurance dept. 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 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 ask if you need help in filing.

INSURANCE ONE TIME AUTHORIZATION:

I understand that my insurance is an arrangement between myself and my insurance company. NOT between Dr. Grimm and my insurance company. I request that Gem City Chiropractic L.L.C. prepare the customary forms at no charge so that my insurance company can process my claims. 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. S.C. that fees will be due and payable immediately.

Gem City Chiropractic L.L.C.

Signature

Date

Guardian Signature

Relationship to Patient

Date

ASSIGNMENT OF BENEFITS

I authorize that any insurance benefits or reimbursement for services rendered when 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. S.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. Notwithstanding 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 L.L.C. (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 be 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

Relationship to Patient

Date