Woodlake Chiropractic

New Patient/CHILD Information

Name: _____

Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Birth date: _____Age: _____ Gender: _____

About the Parent/Guardian

Name: _____

Address (if different from above):

_____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____

Email: _____

Birth date: _____Age: _____ Gender: ____

Are you: ( )Single ( )Married ( )Separated

( )Divorced ( )Widowed ( )Partnered for ____yrs

Employer: _____

Occupation: _____

Work Phone: _____

Reason for the Visit

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

When did this condition begin? _____

Has this condition:

( )Gotten worse ( )Stayed constant ( )Comes and goes

Does this condition interfere with:

( )Sleep ( )Daily routine ( )Other activities

Please explain: _____

Has this been recurring? ( )Yes ( )No

Please explain: _____

Have you seen other doctors for this condition?

( )Yes ( )No

Doctor's Name(s): _____

_____

Type of treatment: _____

_____

Results: _____

_____

_____

Experience with Chiropractic

Who can we thank for referring you to this office? _____

Have you been adjusted by a Chiropractic before? ( )Yes ( )No Reasons for those visits: _____

Doctor's Name: _____ Approximate date of last visit: _____

Have any adults in your family seen a Chiropractor? ( )Yes ( )No

Have any children in your family seen a Chiropractor? ( )Yes ( )No

About the Parent

Were you aware that:

Doctors of Chiropractic work with the nervous system?( )Yes ( )No

The nervous system controls all bodily functions and systems? ( )Yes ( )No

Chiropractic is the largest natural healing profession in the world? ( )Yes ( )No

If Chiropractic care starts at birth you can Achieve a higher-level health throughout life? ( )Yes ( )No

Phone 612.866.9194 Fax 612.866.9963 www.woodlakechiro.com email: woodlakechiro@yahoo.com

Woodlake Chiropractic

Mother's Pregnancy & Labor

Place of delivery: ( )Home ( )Birth Center ( )Hospital

How was your delivery?

( )Labor Chemically Induced
( )Labor was Dr. assisted
( )C-Section Delivery
( )Forceps/Vacuum Extraction
( )Dr. pull or twist baby
( )Premature Delivery

Please explain: _____

_____

_____

Do/did you nurse the baby? ( )Yes ( )No

Does/did your baby have colic? ( )Yes ( )No

Feeding Problems? ( )Yes ( )No

During Pregnancy:

( )Drugs/Medicine ( )Tobacco/Alcohol

Please explain: _____

Any illness during your pregnancy? _____

_____

_____

Childs Health History

Please check each of the disease or conditions that the child has now or has had in the past.

( )Allergies
( )Asthma
( )Attention problems
( )Bed wetting
( )Breathing problems
( )Colic
( )Constipation
( )Digestive problems
( )Ear problems
( )Frequent colds
( )Headaches
( )Hyperactivity
( )Irritability
( )Skin problems
( )Sleeping disorders
( )Tongue tie
( )Tubes in the ears
( )Vision problems
( )Other _____
( )Other _____

Vaccinations

Have you chosen to vaccinate your child? ( )Yes ( )No

If Yes, check all that your child has received:

___DPT ___MMR ___Chicken Pox ___Hepatitis

___Other: _____

Describe any and all reactions to vaccine(s): _____

_____

_____

Child's Current Health Status

Has your child ever:

taken antibiotics?	( )Yes	( )No
been hospitalized?	( )Yes	( )No
had a severe fall?	( )Yes	( )No
been in a car accident?	( )Yes	( )No

If yes, please explain: _____

_____

_____

_____

Is your child:

accident prone?	( )Yes	( )No
currently taking medication(s)?	( )Yes	( )No
Having difficult interacting with others?	( )Yes	( )No

If yes, please explain: _____

_____

_____

_____

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

_____

_____

Authorization for Care of a Minor

I hereby authorize my child's doctors in this chiropractic office, including whomever they deem their assistants, to work with my child's condition through the use of adjustments and procedures the doctor deems appropriate.

I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my child's care, any fees for professional services rendered to my child will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____
Parent or Guardian's Name (PRINT)

_____
Patient's Name (PRINT)

_____
Parent or Guardian's Signature

_____
Date

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Woodlake Chiropractic

Photo Consent

I give permission to Woodlake Chiropractic doctors and staff to use my photographs, videos and any handwritten/emailed testimonials from me for advertising purposes both internal and external. This would include but is not limited to: newsletters, print ads, websites, in office use, and any other promotional item for the office. Should I request to have my photos, videos or written testimonials removed, I will inform the doctors in writing.

_____ _____

Signature of Patient or Guardian Date

X-ray Consent

I hereby give my consent to Woodlake Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge; I am not pregnant. I have read and understood all the above information.

_____ _____

Signature of Patient or Guardian Date

Terms of Acceptance

It is essential that the patient seeking chiropractic care and the Chiropractor whom they select are both working towards the same therapeutic goal. Below we outline our objective and our method in order to prevent confusion or disappointment.

Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or altered nerve function that interferes with the body's innate ability to maintain health.

An **Adjustment** is the specific application of forces to facilities the body's correction of subluxation. Our chiropractic method of correction utilizes specific manual and instrument-assisted adjustments to the spine, other joints in the body, and the nervous system to assist the body in returning to a state of maximum health. Modalities such as exercise, stretching, and soft tissue therapies may be used to achieve the optional well-being of the patient.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Financial Policies

PAYMENT IS DUE AS SERVICE IS RENDERED

However, as a courtesy to our patients, we do allow other payment options withing guidelines of our policy.

1. CASH: We accept cash, check, Visa, Mastercard, American Express, and Discover. Payments for services are due at the time the services are rendered, unless payment arrangements have been approved in advance by our staff. Returned checks maybe subject to a $15.00 service charge in additional to penalties incurred by the banking institution. Savings plans are available for children, families, and adults desiring regular treatments.
2. GROUP INSURANCE: Patients are responsible for payment in full at the time of and for the first visit. If out of network, the patient is responsible for submitting all claims to their insurance company for reimbursement.
3. WORKER'S COMPENSATION: Patients are required to fill out a worker's compensation questionnaire. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases.
4. ACCIDENT/PERSONAL INJURY: Patients are required to complete a personal injury questionnaire and/or an accident report form. If you have been involved in a motor vehicle accident, it is important that your report the accident to your insurance agent. You must ask for a claim number and obtain the appropriate billing information. If an attorney is involved, please let us know.
5. MEDICARE: We will submit all claims to Medicare for you. You are responsible for payment of all services at the time of service. This would include x-rays, examinations, adjustments, supports, nutrition, and therapy. You must provide your Medicare card at the first visit. If you have a secondary insurance, we will bill Medicare, but you are responsible for submitting any unpaid balance to your secondary insurance.
6. MEDICAL ASSISTANCE: We do not accept assignment for Medical Assistance in our office. Savings plans are available for people on social security.

Acknowledgment of Receipt of Privacy Practices

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Woodlake Chiropractic which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

If you have any questions or comments regarding our terms, policies, we are happy to assist you.

_____ _____ _____

Name of Patient Signature of Patient or Guardian Date

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