

Batesville Spine & Health Solutions

Patient Information (CHILD)

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Birth Date: ____/____/____

City, State, Zip: _____ Cell Phone: () _____

Name of Mother/Guardian: _____ Home Phone: () _____

Birth Date: ____/____/____ (Age) _____ Marital Status: S M D W Work Phone: () _____

Home Address (if different): _____ Cell Phone: () _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: _____ Home Phone: () _____

Birth Date: ____/____/____ (Age) _____ Marital Status: S M D W Work Phone: () _____

Home Address (if different): _____ Cell Phone: () _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? Yes No If yes, when: ____/____/____

**If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe incident or reason for onset of symptoms: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin? ____/____/____ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes No Do they interfere with: School Sleep Hobbies/Play Daily Routine

Explain: _____

What activities aggravate these symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain: _____

Has your child been treated for this? Yes No When was the last treatment? ____ / ____ / ____

Name of treating practitioner/facility? _____

What treatment(s) was performed? _____

How did your child respond? _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

A = ACHE

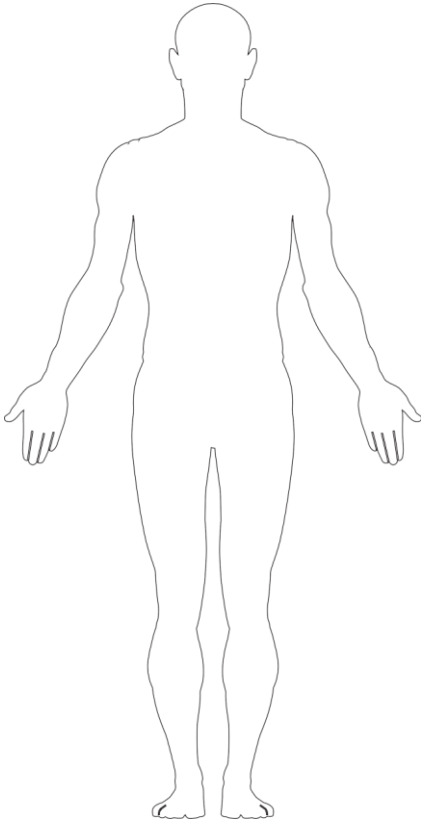
G = STABBING

N = NUMBNESS

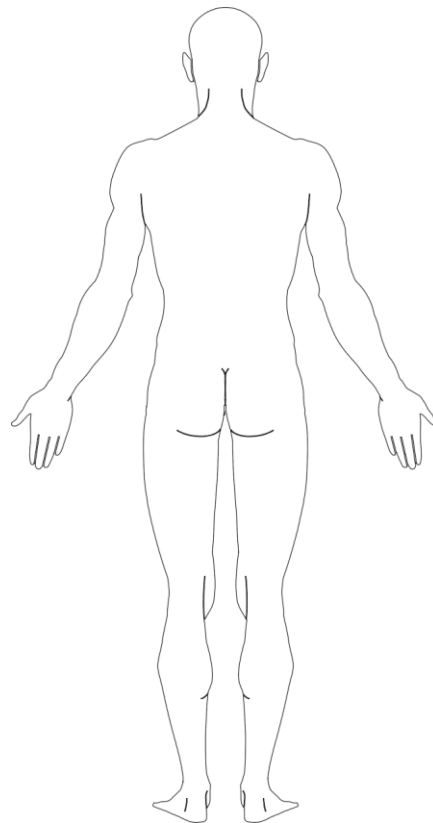
B = BURNING

M = SPASMS

T = TINGLING



P = PINS & NEEDLES



F = STIFFNESS

O = OTHER

FRONT

BACK

If you marked "O" for Other on any part, please explain below:

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.¹ Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma*
- Rough shaking as an infant
- Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
- Experience broken bones or debilitating injuries*
- Difficult Birth (see below)

Explanation of (*) item(s): _____

Birth Experience:

How long was labor? _____

Describe any complications: _____

Type of delivery: Vaginal C-Section Vacuum Extraction Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: ____ Mos. Yrs. Where received: _____
2. _____ Age: ____ Mos. Yrs. Where received: _____
3. _____ Age: ____ Mos. Yrs. Where received: _____
4. _____ Age: ____ Mos. Yrs. Where received: _____
5. _____ Age: ____ Mos. Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

- | | | |
|---|---|--|
| <input type="checkbox"/> Swelling, redness, heat/hardness of site | <input type="checkbox"/> Body rash or hives | <input type="checkbox"/> High fever (over 103 degrees) |
| <input type="checkbox"/> High-pitched screaming | <input type="checkbox"/> Extreme sleepiness or unresponsiveness | <input type="checkbox"/> Body twitching or paralysis |
| <input type="checkbox"/> Breathing problems (asthma, etc.) | <input type="checkbox"/> Excessive bleeding or anemia | <input type="checkbox"/> Head banging |
| <input type="checkbox"/> Excessive diarrhea or chronic constipation | <input type="checkbox"/> Loss of memory/foggy state | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Chronic ear or respiratory Infections | <input type="checkbox"/> Vision or hearing disturbances | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Crossing of eyes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other (please explain) |

Explanation(s): _____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain in shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flu |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Flu/Stomach disorders |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Hyperactivity/ADD |
| <input type="checkbox"/> Auto-Immune Diseases | <input type="checkbox"/> Other (please explain) | |

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Pain in Ribs/Chest | <input type="checkbox"/> Pain On Deep Inspiration/Expiration |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Indigestion/Heartburn/Reflux | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Recurrent Lung Infection/Bronchitis | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Muscle cramps in legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Other (please explain) | |

OTHER

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): _____

Please list any surgeries (include type of surgery and date it was performed): _____

Family Health History

Have any of your family members ever been diagnosed with the following? *If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).*:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Allergies/Hay fever* | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Blood sugar problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Chicken pox/shingles |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Eczema | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Fetal drug exposure | <input type="checkbox"/> Food allergies* | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Rash | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Spinal Bifida | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Other* |

Explanation of (*) item(s):

Experience with Chiropractic

Has your child seen a Chiropractor before? Yes No Who? _____

Reason for visit(s): _____

Did the previous chiropractor take 'before' and 'after' x-rays? Yes No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? Yes No Did they recommend a Home Health Care program? Yes No

If yes, what? _____

How long was your child treated? _____ Last treatment: ____ / ____ / ____

How did your child respond? _____

Are you aware of any poor posture habits in your child? Yes No Is there any history of spinal problems in your family? Yes No

If yes, explain: _____

Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____ / ____ / ____

Guardian Signature _____ Date ____ / ____ / ____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that he/she will not receive the full benefit from these programs; and that if I terminate this care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date __/_____/____

Patient's Name Printed _____

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date ____/____/____

In Case of Emergency

Name _____ Relationship _____

Work Phone () _____

Home Phone () _____

Cell Phone () _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? Yes No

Signature of Person Authorizing Care:

_____ Date ____ / ____ / ____

Relationship to Insured _____ Date of Birth ____ / ____ / ____

Employer _____

Primary Insurance Company _____ **Policy#** _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____

Secondary Insurance Company _____ **Policy#** _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____