New Pediatric Member Form

APEX CHIROPRACTIC

Name:_____Date:_____

Parent/Guardian:_____
Phone #: _____
Email : _____

Age:_____ Birthday:_____/_____/_____
Male Female

Address : _____
_____
City:_____
State::_____ Zip:_____

Other Caregiver:_____
Phone #: _____
Email: _____

Emergency Contact: _____
Phone #:_____

From Whom or Where/How did you hear about Apex Chiropractic?

- _____

My Main Health Concerns

A	B	C
Issue:_____	Issue:_____	Issue:_____
Started: _____	Started: _____	Started: _____

Quadruple Visual Analogue Scale

Please write the corresponding letter to each of your main health concerns above (A, B, C) on the scale for each of the four questions below.

- How would you rate your pain RIGHT NOW?

No Pain ← 0 1 2 3 4 5 6 7 8 9 10 → Worst Pain

- What is your TYPICAL or AVERAGE pain?

No Pain ← 0 1 2 3 4 5 6 7 8 9 10 → Worst Pain

- What is the LEAST your pain ever is?

No Pain ← 0 1 2 3 4 5 6 7 8 9 10 → Worst Pain

- What is your pain level at its WORST?

No Pain ← 0 1 2 3 4 5 6 7 8 9 10 → Worst Pain

Any other health concerns you are dealing with?

Please mark "C" for issues you are currently dealing with or "P" for things you have dealt with in the past.

___Headaches
___Migraines
___Dizziness
___Vertigo
___Nausea
___Anxiety
___Allergies

__Ear Infections
__Asthma
__High Blood Pressure
__Chronic Fatigue
__Chest Pain
__Nervousness
__ADD/ADHD

__Sinus Problems
__Epilepsy
__Heart Disorder
__Digestive Issues
__Bladder Problems
__Menstrual Issues
__TMJ Pain

__Arm/Hand Numbness
__Leg/Foot Numbness
__Sciatica
__Carpal Tunnel
__Kidney Problem
__Thyroid Problem
__Fibromyalgia

Name of Pediatrician:_____

Date of last visit:_____ Phone Number:_____

Current prescription drugs and dosage:

_____

Past prescription drugs and dosage:

_____

Other over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____

Prior Chiropractic Care?: Yes No Date of last visit:_____

Check any conditions you have now/have had:

___Stroke
___Scoliosis
___Cancer
___Diabetes
___Heart Disease
___Seizures
___Spinal Surgery
___Spinal Bone Fracture

Lifestyle

Does your child: ☐ Eat Healthy Food (Organic products, etc) ☐ Drink Water
☐ Take probiotics ☐ Take Vitamins Type:_____

Exercise: ☐ None ☐ Mild ☐ Moderate ☐ Heavy ☐ Daily

Has your child been involved in any sports? Yes No List:_____

Has your child had a fall or another traumas (bike fall, trampoline injury, etc.)?

_____

Has your child been seen by a physician on an emergency basis? Yes No
Explain: _____

Activities of Daily Living:

Please mark how your current condition is affecting your ability to carry out activities that are routinely part of your life:

	No Effect	Painful (can do)	Painful (limited)	Unable to Perform
Lift/Carry Heavy Objects				
Walk				
Run				
Sit				
Stand				
Sit to Stand Motion				
Exercise				
Climb Stairs				
Pet Care				
Household Chores				
Eat				
Sleep				
Personal Care				
Concentrate				
Use Technology				
Driving				
OTHER:_____				

Last But Not Least!

What is your goal to achieve through Chiropractic Care??

Sleep Better?

Spend more time with my family, doing the things I love?

My Goal!

Play without pain?

By signing below, I am acknowledging that I am a parent/guardian of the above child, and I have filled out all the above accurately and to the best of my ability.

Print Name _____ **Signature** _____ **Date**_____

Note of Privacy Practices Acknowledgement

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

Permitted Disclosures:

- Treatment purposes - discussion with other health care providers involved in your care
- Inadvertent disclosures - open treating area means open discussion, If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room
- For payment purposes - to obtain payment from your insurance company or any other collateral source
- For worker's compensation purposes - to process a claim or aid in investigation
- Emergency - in the event of a medical emergency, we may notify a family member
- For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
- To governmental agencies or law enforcement - to identify or locate a suspect fugitive, material witness, or missing person
- Deceased persons - discussion with coroners and medical examiners in the event of a patient's death
- Telephone calls or emails and appointment reminders - we may call you home/cell and leave voice/text messages regarding an appointment , a missed appointment, or notify you of changes in practice hours or upcoming events
- Announcing names in queue at the front desk & reception area - we announce the first and last names of patients in queue that are waiting to be treated(eg. "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed
- Change of ownership - in the event this practice is sold, the new owners would have access to your Personal Health Information

Your rights:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive Detail Privacy Notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is essential for both parties to be working towards the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes in called a neurostructural shift.
- The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctor of chiropractic in the United States alone.
- Chiropractic does not seek to replace of compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

No-Show, No- Communication Fee Policy

At Apex Chiropractic, we highly value your time and we are fully committed to your success. We also ask that our practice members do the same to provide the best experience possible for everyone. To ensure this, our no-call no-show policy will involve the following: Any missed appointment with no contact from the practice member, we will bill your account $30 for not keeping your scheduled appointments, and taking a spot that someone else could have utilized. After 3 missed appointments in a row, your future appointments will be removed until contact is made.

Informed Consent for Chiropractic Care

Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is often very minimal. Yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is ay reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below:

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Dr. Kamen Blau. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for the services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by his assignment.

Name of Practice Member Who is a Minor/Child:_____

- I authorize Dr. Kamen Blau, and any and all Apex Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Apex Chiropractic.

Parent/Guardian Signature: _____Date:_____

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Apex Chiropractic, or anyone authorized by Apex Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negative and positives, together with the prints shall constitute the property of Apex Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposed previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Apex Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature:_____Date: _____