Pediatric Member Form

APEX CHIROPRACTIC

Name:_____Date:_____

Age:_____ Birthday:_____/_____/_____ Male Female
Weight: _____ Height:_____

Address: _____ City:_____
State:_____Zip Code:_____

Mother :_____ Phone Number:_____
Father:_____ Phone Number:_____
Other Caregiver:_____ Phone Number: _____
Emergency Contact:_____ Phone Number:_____
Email: _____

How did you hear about Apex Chiropractic?

_____

Reason for seeking Chiropractic Care:
☐ Maintenenance ☐ Improve Health ☐ Problem:_____
Any Family History of Illnesses?: _____
_____
_____

Circle any of the following conditions that currently apply:

Ear Infections	Scoliosis	Chronic Colds	Headaches
Digestive Problems	Allergies	ADD/ADHD	Recurring Fevers
Growing Pains	Colic	Seizures	Temper Tantrums
Bedwetting	Asthma	Car Acident: When? _____	
Other: _____		Other:_____	

Other doctors seen for this condition (Please include doctor's name and prior treatment):
_____
_____
_____

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

Name of Pediatrician:_____ Date of last visit:_____
Phone Number:_____
Are you satisfied with the care your child has received at the pediatrician? ☐ Yes ☐ No

# of Doses of antibiotics you child has take: Past 6 months _____ Total Lifetime:_____

Current prescription drugs and dosage: _____

Past prescription drugs and dosage:_____

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

Prenatal History

Name of Obstetrician/Midwife:_____

Complications during pregnancy/delivery? ☐ Yes ☐ No Explain:_____

Ultrasounds during pregnancy? ☐ Yes ☐ No How Many?:_____

Medication taken during pregnancy/delivery? ☐ Yes ☐ No List:_____

Cigarette/ Alcohol use during pregnancy? ☐ Yes ☐ No

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section
If Caesarian, was it: ☐ Emergency ☐ Planned

Genetic Disorders/ disabilities? ☐ Yes ☐ No List:_____

Birth Weight: _____ Birth Height:_____ APGAR Scores: _____-_____

Feeding History

Breast Fed: ☐ Yes ☐ No How Long?_____

Formula Fed: ☐ Yes ☐ No How Long?_____

Introduced to: Solid Food @ _____ Months Cow's milk @ _____ Months

Food/Juice allergies or intolerances ☐ Yes ☐ No List:_____

Development History

Your child's spine is vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of neuro-structural shifts. The following can be affected by neuro-structural shifts. At what age was your child able to:

_____Respond to Stimuli _____Cross Crawl _____Stand Alone _____ Sit Up

_____Respond to Visual Stimuli _____ Hold Head Up _____Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did your child have a fall similar to what was described above?
☐ Yes ☐ No Explain:_____

Other traumas not described above (bike fall, trampoline injury, etc.)?

_____

Has your child been involved in any sports? ☐ Yes ☐ No

List:_____

Has your child been seen by a physician on an emergency basis? ☐ Yes ☐ No

Explain: _____

Lifestyle

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

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

Hobbies/ Interests: _____

Is there anything else you would like us to know about your child?_____
_____

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, it is our top priority to ensure that your time is respected to the utmost degree. We also ask that our practice members do the same to ensure that everyone has a pleasant experience. In light of this, it is our office policy that there are three (3) consecutively scheduled appointments that are missed without any form of communication (phone call, email, sms message), there will be charged $100 to a card on file until communication is received from the practice member to cancel/postpone future appointments or until a schedule visit is attended by the practice member.

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: _____