



TOTAL HEALTH

SPINE & NUTRITION

PEDIATRIC PATIENT APPLICATION FORM

WELCOME and THANK YOU for trusting us with your child/children applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and teenagers with early onset to advanced spinal distortion and injuries known to cause lifelong health problems. Because of this, we may not accept your child as a patient until we are absolutely certain we know what is causing their condition, can perform the necessary tests to determine the optimal program of correction, and are completely confident you and your child place their health as a TOP PRIORITY. Please know if we do accept you as a patient, we will make specific recommendations at that time. Thank you again for giving your child the opportunity to apply as a patient in our clinic.

PATIENT NAME

DATE COMPLETED

PERSONAL INFORMATION

First Name: _____ MI _____ Last Name: _____

Address: _____ Age: _____ Gender: M F

City/State/Zip: _____ Birth Date: ____ / ____ / ____

*Email (required): _____ Cell/Home Phone: _____

*You will automatically be enrolled to receive **protected** health records through **Patient Fusion**. This allows you to gain online access to your medical records.

Name of Mother/Guardian: _____ Cell/Home Phone: _____

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

Address (if different): _____ City/State/Zip: _____

Occupation: _____ Employer's Name: _____

Name of Father/Guardian: _____ Cell/Home Phone: _____

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

Address (if different): _____ City/State/Zip: _____

Occupation: _____ Employer's Name: _____

How were you referred to our office?: TV Drive By Internet Insurance Co.
 Friend/Family: _____ Other: _____

Pediatrician Name/Practice Name: _____ Phone: _____

Has your child seen a Chiropractor before? Yes No If Yes, When: _____

Where: _____ Results: _____

Did the previous Chiropractor take 'before' and 'after' x-rays? Yes No

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

Are you aware of any poor posture habits in your child? Yes No

If yes, explain: _____

Please List Your Child's TOP 2 Complaints/Symptoms

Complaint #1	Type of Pain:	Worse with which of these activities:	Result of:
<p>_____</p> <p>_____</p> <p>Began?: _____</p> <p>Has he/she had this before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is it Getting Worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant</p>	<p><input type="checkbox"/> Aching <input type="checkbox"/> Tight</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Stiff</p> <p><input type="checkbox"/> Deep <input type="checkbox"/> Tender</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Numb <input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> Sharp/ Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Sore</p>	<p><input type="checkbox"/> Lying on back <input type="checkbox"/> Stooping</p> <p><input type="checkbox"/> Lying on side <input type="checkbox"/> Bending</p> <p><input type="checkbox"/> Lying on stomach <input type="checkbox"/> Twisting/Turning</p> <p><input type="checkbox"/> Turning over <input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Dressing self <input type="checkbox"/> Walking</p> <p><input type="checkbox"/> Pushing <input type="checkbox"/> Climbing</p> <p><input type="checkbox"/> Pulling <input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Lifting <input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Reaching <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Auto Accident</p> <p><input type="checkbox"/> Injury/Fall</p> <p><input type="checkbox"/> Other (Describe):</p> <p>_____</p> <p>_____</p>
<p>_____</p> <p>_____</p> <p>Began?: _____</p> <p>Has he/she had this before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is it Getting Worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant</p>	<p><input type="checkbox"/> Aching <input type="checkbox"/> Tight</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Stiff</p> <p><input type="checkbox"/> Deep <input type="checkbox"/> Tender</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Numb <input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> Sharp/ Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Sore</p>	<p><input type="checkbox"/> Lying on back <input type="checkbox"/> Stooping</p> <p><input type="checkbox"/> Lying on side <input type="checkbox"/> Bending</p> <p><input type="checkbox"/> Lying on stomach <input type="checkbox"/> Twisting/Turning</p> <p><input type="checkbox"/> Turning over <input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Dressing self <input type="checkbox"/> Walking</p> <p><input type="checkbox"/> Pushing <input type="checkbox"/> Climbing</p> <p><input type="checkbox"/> Pulling <input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Lifting <input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Reaching <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Auto Accident</p> <p><input type="checkbox"/> Injury/Fall</p> <p><input type="checkbox"/> Other (Describe):</p> <p>_____</p> <p>_____</p>

HEALTH & LIFESTYLE

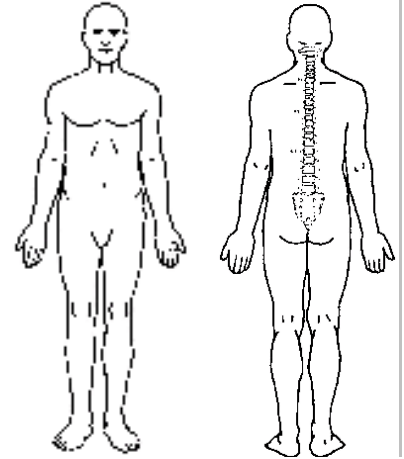
Is this condition interfering with your (Check all that apply):

School Sleep Daily Routine Hobbies/Play Other: _____

Have you received any treatment for this condition? Yes No

If Yes, please explain: _____

Please "X" your areas of pain on the figures below:



HABITS

Soft Drinks Drinks/Day: _____
 Water Glasses/Day: _____
 Vitamins List: _____
 Sports List: _____
 Hobbies List: _____

EXERCISE

None
 1-2 days/week
 3-4 days/week
 5+ days/week
Type of Exercise: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Cell/Home Phone: _____

Work Phone: _____

Address: _____

City/State/Zip: _____

ELECTRONIC HEALTH RECORDS (EHR) INFORMATION

Demographics

Ethnicity: Hispanic Non-Hispanic

Preferred English Spanish

Language: Other: _____

Race: White/Caucasian African American

Native American Hawaiian/Pacific

Asian Other: _____

Are you allergic to any medications? Yes No

If yes, please list those medications and the problem experienced?

Do you smoke now? Yes No

Have you ever been a smoker? Yes No

Use any other form of tobacco? Yes No

CHECK THE FOLLOWING HEALTH CONDITIONS AS THEY APPLY TO YOU

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck 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 if you have had any of these conditions in the Past, Now, or Both.**

Past Now

Neck Pain
 Pain in shoulders/arms/hands
 Numbness/tingling in arms/hands
 Weakness in grip
 Cold hands
 Headaches/Migraines
 Colic

Past Now

Low energy/fatigue
 Sore throats
 Anxiety/Depression
 Sleep problems
 Recurrent Colds/Flu
 Allergies/hay fever
 Hyperactivity/ADD

Past Now

Sinus congestion/infections
 Hearing disturbances
 Visual disturbances
 Dizziness/vertigo
 Thyroid conditions
 TMJ/Pain/Clicking
 Learning Disabilities

Please explain: _____

HEALTH CONDITIONS CONTINUED...

THORACIC SPINE (MID AND UPPER BACK)

Misalignment of the individual vertebrae or distortion of the thoracic curve (upper and mid back) originating in the mid 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 if you have had any of these conditions in the Past, Now, or Both.**

Past Now

- Upper Back Pain/Stiff/Tight
- Mid Back Pain/Stiff/Tight
- Tachycardia (racing heart)
- Palpitations
- Heart Murmurs
- Liver Problems
- Spleen Problems

Past Now

- Shortness of breath
- Asthma/wheezing
- Lung Infections/Bronchitis
- Pain w/ deep breaths
- Pain in ribs/chest
- Heartburn/Reflux
- Tired/irritable after eating
or when not having eaten for awhile

Past Now

- Ulcers
- Gas
- Nausea
- Stomach aches/cramping
- Diabetes
- Gall Bladder Problems

Please explain: _____

LUMBAR SPINE/PELVIS (LOW BACK/HIPS)

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 if you have had any of these conditions in the Past, Now, or Both.**

Past Now

- Low Back Pain
- Pain in the hips/legs/feet
- Numbness/Tingling in legs/feet
- Weakness/injuries in hips/
knees/ankles

Past Now

- Cold feet
- Muscle cramps in leg/feet
- Constipation
- Diarrhea
- Recurrent bladder infections

Past Now

- Frequent/difficulty urinating
- Unable to control urine
- (Females) Irregular cycles/
cramping
- Kidney stones

Please explain: _____

ADDITIONAL INFORMATION

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

Please list any other health conditions, diseases, or surgeries (tonsils, appendectomy, cancer, epilepsy, etc): _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on my child by Total Health Spine & Nutrition and staff who now or in the future treat me while employed by Total Health Spine & Nutrition.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my child's condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my child's symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment.

Patient Signature

Date Signed

Guardian Name & Relationship to Patient

Guardian Signature

Date Signed

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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: _____

Patient Signature

Date Signed

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize the doctor and whomever he/she may designate as assistance to administer chiropractic care as he/she deems necessary to my child.

Signature of Parent or Guardian

Date Signed

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Total Health Spine & Nutrition's "Notice of Privacy Practices" published April 14, 2003 has been provided to me.

I understand I have a right to review Total Health Spine & Nutrition's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Total Health Spine & Nutrition.

The Notice of Privacy Practices for Total Health Spine & Nutrition is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Total Health Spine & Nutrition's duties with respect to my protected health information.

Total Health Spine & Nutrition reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Total Health Spine & Nutrition's website.

I have the right to revoke this consent, in writing, except to the extent that Total Health Spine & Nutrition has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature or Personal Representative

Date Signed

Description of Personal Representative's Authority

PATIENT INFORMATION RELEASE AUTHORIZATION

I hereby authorize Total Health Spine & Nutrition to release information contained in my patient records to the individual(s) and only under the conditions listed below:

Name of person(s) to whom information can be disclosed to (i.e. spouse, family member, friend, another doctor, etc):

Specific type of information to be disclosed (i.e. all records, x-rays, blood tests, etc):

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

Patient Signature

Date Signed

Parent or Guradian Signature

Date Signed

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Total Health Spine & Nutrition. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Spine & Nutrition responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date Signed

Parent or Guardian Signature

Date Signed