Eugene Family Chiropractic

We are honored that you have chosen us to assist you and your family's health & wellness needs. Please let us know if there is any way we can make you and your family more comfortable. We look forward to working with you to build better health for your family.

Pediatric History & Adolescent Form (birth to 16 years)

Patient Name: _____ Last name _____ Middle Initial_____ Nick-Name _____ Date _____

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

Birth Date: ____/____/_____ Sex: _____ Weight: _____ Height: _____

Whom may we thank for referring you to our office? _____

Father's Name:_____ Mother's Name: _____

Father's Cell Phone: _____ Carrier: _____

Mother's Cell Phone: _____ Carrier: _____

Home Phone: _____ Email: _____

Parent's marital status (please circle): Single Married Divorced Widowed

In the event we need to contact you, what is the best method of communication for your family? (circle one) Phone E-Mail

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may about yourself or the other members of your family:

Yourself/Spouse:_____

Other Children:_____

Others: _____

Purpose for Contacting Us (please circle any) of the following:

Spinal Check-Up Wellness Other

Please Explain:_____

If Applicable: Other Doctors Seen for This Condition: ____No ____ Yes

Doctor's Name & Prior Treatments:_____

Previous Chiropractor: _____

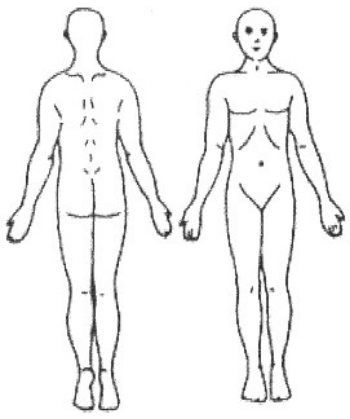
Date of Last Visit: ___/___/_____ Reason:_____

Name of Pediatrician: _____Date of Last Visit: ___/___/_____ Reason: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Key: A=Ache B=Burning N = Numbness **P=Pins & Needles S=Stabbing**

How would you rate your pain? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐Yes ☐No. When? _____

Is the Condition: ☐Auto Related ☐Home Injury ☐Slip or Fall

☐Lifting ☐Slept Wrong ☐Unknown Cause ☐Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

Your Child's Health Profile:

Vaccination History:

(Please check) __Up to Date __ Chose to decline Vaccinations __Still Deciding

Please describe any adverse reactions to vaccinations: _____

Please mark if your child has or has had any of these conditions.

__ Ear Infection	__Scoliosis	__Seizures	__Chronic Colds
__Headaches	__Asthma	__Allergies	__Digestive Problems
__ADHD	__Recurrent Fevers	__Growing Pains	__Colic
__Bedwetting	__Anemia	__Reflux	__Behavioral Problems
__Leg Problems	__Poor Posture	__Broken Bones	__Heart Trouble
__Stomach Aches	__Muscle Pain	__Orthopedic Problem	__Neck Problems
__Joint Problems	__Constipation/diarrhea	__Poor appetite	__Arm Problems
__Back Problems	__Walking Trouble	__Sinus Trouble	__Diabetes

Other: _____

Number of doses of Antibiotics your child has taken: _____

Please list any drugs or medications (prescription or over the counter) your child is taking:_____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during Pregnancy: ___ No ___ Yes List: _____

Medications during Pregnancy/Delivery: ___ No ___Yes List: _____

Cigarette/Alcohol use during Pregnancy: ___ No ___Yes List: _____

Location of Birth: __ Hospital __ Birthing Center __ Home

Birth Intervention: __ Forceps __ Vacuum Extraction __ Cesarean Section (emergency or planned?)

Complications during Delivery: __No __Yes List: _____

Genetic Disorder or Disabilities: __No __Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: 1 min_____ 5 min_____

Feeding History:

Breastfed: ____ No ____ Yes How long? _____

Formula fed? ____ No ____ Yes How long? _____, which formula? _____

Does the baby prefer feeding on one side than the other? ____Yes ___ No

Introduced to solids at: _____ Months, Cows Milk at _____ Months.

Food/Juice Allergies, Sensitivities, or Intolerances: ___ Yes ___ No List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely be checked by a doctor of chiropractic for prevention and early detection of ***vertebral subluxation*** (spinal nerve interference). At what age was your child able to:

_____ Respond to Sounds _____Cross Crawl _____Hold Head Up

_____Sit Up _____Stand Alone _____Walk Alone

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please (X) the appropriate answer to the following questions with the best of your ability.

Did your child have a traumatic birth? [ ] Yes [ ] No [ ] Unsure

Has your child had any serious falls? [ ] Yes [ ] No [ ] Unsure

Did/Does your child play youth sports? [ ] Yes [ ] No [ ] Unsure

Has your child been involved in a car accident? [ ] Yes [ ] No [ ] Unsure

Has your child been under chiropractic care? [ ] Yes [ ] No [ ] Unsure

On average, how many hours of sleep does your child get per night? _____

Bio-Chemical (Ages 3 and above)

Please write ***Never*** *(0 days),* ***Rarely*** *(1-2 days),* ***Occasionally*** *(3-5 days), or* ***Always*** *(6-7 days)* for the statements below. (Questions are based on days/week)

Does your child drink 2-8oz glasses of water? _____

Does your child take a fish oil supplement? _____

Does your child eat 4-8 servings of fruits & vegetables? _____

Does your child consume splenda, or other artificial sweeteners? _____

Does your child eat fast food? _____

Does your child take medication? _____

Does your child eat processed, packaged, or pre-made foods? _____

Does your child eat sugary snacks, candies, or cereals? _____

Does your child drink soda? _____

Does your child eat white bread or pastas? _____

Lifestyle (Ages 5 and above)

Please write ***Never*** *(0 days),* ***Rarely*** *(1-2 days),* ***Occasionally*** *(3-5 days), or* ***Always*** *(6-7 days)* for the statements below. (Questions are based on days/week)

Does your child have difficulty concentrating? _____

Does your child complain of feeling overwhelmed or frustrated? _____

Does your child get angry easily? _____

Does your child feel confident in social settings? _____

Does your child get at least 1 hour of physical activity daily? _____

With which physician(s) do you want us to coordinate care?:

(Circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other

Dr.'s Name:_____

Clinic's Name & Location_____

Informed Consent & Authorization to Treat a Minor:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Elizabeth Washak, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Eugene Family Chiropractic, LLC.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the abovenamed procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received Eugene Family Chiropractic's HIPAA notice and understand the policy for my protected health information.

Consent to treat a Minor: _____ Date:_____

Guardian or Parent's Signature of Authorizing Care: _____

Other Guardian or Parent's Signature of Authorizing Care: _____

Cancellation/Missed Appointment Policy:

We require at least 24 hours advanced notice if you need to cancel your appointment. For all missed or cancelled appointments less than 24 hours' notice, you will be charged a $25 cancellation fee. Appointment reminder calls/emails/texts are a courtesy. Should you not receive a reminder call/text/email, it is still your responsibility to remember your appointment.

I agree to the above terms and authorize you to bill the charge card. I understand that should my child miss their appointment without giving 24 hours' notice, I will be charged the amount of $25

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Eugene Family Chiropractic 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 Eugene Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Elizabeth Washak, D.C. However, I clearly understand and agree that all services rendered to me are my personal responsibility. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn't been received in 30 days from terminating care, I authorize deduction from my credit card.

Please Note: Insurance companies do not pay for care that is not medically necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contracted discount under the following circumstances:

- **If we are a participating provider in your health plan.**
- **If you are covered by a State or Federal program with a mandated fee schedule.**
- **We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.**
- **If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option.**
- **Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.**

As part of our compliance plan, our office will be unable to extend any type of discounts other than those listed above.

Consent to treat a Minor: _____ Date:_____

Guardian or Parent's Signature of Authorizing Care: _____

Other Guardian or Parent's Signature of Authorizing Care: _____