FERGUSON FAMILY CHIROPRACTIC CHILDREN'S HEALTH HISTORY FORM

Today's Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Cell phone (_____) _____	Cell phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

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

Would you like to sign up for our monthly email newsletter? ____YES ____NO

Would you be interested in signing a release to be featured on our social media? ____ YES ____ NO

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Ferguson Family Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

PREGNANCY OF MOTHER & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malposition? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ MMR _____ ❑ Other _____
❑ Polio _____ ❑ Chicken Pox _____
❑ Hepatitis _____ ❑ Flu _____

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply	❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath
	❑ Massage Therapist	❑ Psychotherapist	❑ Energy Healer	❑ Other

Reason _____

_____

Financial Agreement:

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to provide excellent service to you. Payment is due at time service is rendered. You will be responsible for fees my for all services you receive.

- Should you discontinue care at any time you am still responsible for outstanding bills/charges.
- If you are on a payment plan, you will be responsible for the outstanding balance for care you have already received, and have not fully paid for.
- I am responsible for any amounts not covered by my insurance.

Time of Service Discount Options (TOS)	$115
TOS Re-exam	$ 55
TOS Medicare Exam	$60
TOS Spinal Adjustment	$45
TOS Kinesio Therapy	$15
TOS EMS, Ultrasound, ART	$12

**TOS – A discounted fee that must be paid at the "Time Of Service"

**We also offer family plans for patients and their family! Please ask for more details

INSURANCE INFORMATION

✹ Insurance

Insurance coverage varies greatly. We will verify chiropractic coverage specific to your plan and estimate what will be due. Payment must be made each visit for services not covered or patient responsibility amount. This is not a guarantee but only an estimate of charges not covered. Additional charges may apply based on your insurance coverage.

✹ **Personal Pay**

Most of our patients pay for care "out of pocket", even those with insurance reimbursement plans. Our discounted time of service plans allow you to receive all the care necessary for you to *regain your health at an affordable fee*. We will be happy to provide you with *monthly statements* for *insurance reimbursement*.

✹ **Personal Injury/accident, Worker's Compensation Insurance**

If you have an auto accident, a worker's compensation injury a personal injury (or other insurance that requires direct billing) you will be expected to complete all the paperwork necessary for us to file the claim on your behalf. If paperwork is not completed within the first week of care, you will be expected to pay for your chiropractic care.

- ✹ PIP forms filled out. Date of Accident_____
- ✹ Injury reported to Employer. Date of Injury_____

TERMS AND CONSENT TO CARE

(Please read and sign)

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective as this prevents any confusion or disappointment.

The objective of chiropractic health care in this office is to ***improve and optimize the health and function of the spine and nerve system through the correction of Vertebral Subluxation[1].*** A **Chiropractic Adjustment** is the method used for the correction of Vertebral Subluxations.

We do not diagnose or treat disease. We analyze the spine for Vertebral Subluxations. If during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our commitment to your health is to (1) **evaluate and monitor** your spine and nerve system **on each visit** to determine the adjustment and adjusting procedures that will get the best outcome for you and (2) to provide you with supportive **education and information** so you can make the best health choices.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Brian Ferguson, Dr. Amanda Ferguson, Dr. LaRissa Tilley, Dr. Emily Rehm, Dr. Nate Betts and Dr. Peter Ferguson permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature of Parent (for minor):_____ Date: _____

***We kindly ask that if you need to reschedule or cancel your appointment that you give at least 24 hours notice. Thank you for understanding that our time is valuable.**

Thank you for choosing Ferguson Family Chiropractic.
We look forward to helping you.