



# Community Chiropractic

7651 E US Hwy 36

Avon, IN 46123

(317) 272-7988

## Child Chiropractic Case History

Date: \_\_\_\_\_

Doctor:  Vicki Danis, DC

Traci Minear, DC

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Parents: \_\_\_\_\_

Who can we contact in case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor/Pediatrician: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

Major Medical  Worker's Compensation  Medicaid  Medicare  Auto Accident

Medical Savings Account & Flex Plans  Other

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_



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PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

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Traci Minear, DC

## HISTORY OF PRESENT AND PAST ILLNESS:

Reason for visit: \_\_\_\_\_

Start date of symptom(s): \_\_\_\_\_

Does anything make the symptom(s) better? \_\_\_\_\_

Does anything make the symptom(s) worse? \_\_\_\_\_

Has your child ever had the same or a similar condition?  Yes  No If yes, when and describe: \_\_\_\_\_

Who else has been consulted for this symptom? \_\_\_\_\_

Date of last doctor visit or examination: \_\_\_\_\_

## CHILDHOOD EXPERIENCE:

Please describe the childbirth experience in detail: \_\_\_\_\_

Is there any history of Major illness, surgery, trauma (such as a car accident) or broken bones? If so, describe and date: \_\_\_\_\_

## HISTORY OF VACCINATION:

Hepatitis B  Rotavirus  DTaP  Hib (H Influenza)  PCV (Pneumococcus)  IPV (Polio)  Flu

Tetanus  Varicella Zoster  Hep A  MMR  HPV  Meningitis

## MEDICATION:

What medications or drugs is your child taking? \_\_\_\_\_

Does your child have any allergies to any medications?  Yes  No

If yes, describe: \_\_\_\_\_

Does your child have any allergies of any kind?  Yes  No

If yes, describe: \_\_\_\_\_

Does your child have any Congenital Condition?  Yes  No If YES, Describe \_\_\_\_\_



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DATE \_\_\_\_\_

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## PREVIOUS CHIROPRACTIC CARE:

Has your child received chiropractic care previously? \_\_\_\_\_

If so, where? \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Describe your/their experience: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

Please indicate below if any of the following are in the child's family history, going back within the last two generations.

Cancer What kind? \_\_\_\_\_

Stroke

High Blood Pressure

Diabetes

Scoliosis

Epilepsy

Migraines

Other Describe: \_\_\_\_\_

I certify the information provided is accurate to the best of my knowledge:

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_