Welcome to
Align Chiropractic Wellness Center!

ALIGN
CHIROPRACTIC
WELLNESS CENTER, LLC

Many of the health challenges that people will face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, physical, or chemical. **This health record is designed to help us understand the stressors your child might have already experienced and to maximize your child's health and wellness.**

Name_____
DOB_____ Age_____
Address_____
City _____ State _____ Zip Code_____
Parent/Guardian Phone Number:_____

Parent/Guardian Name(s): _____
_____

Who may we thank for referring you and your child to our office:_____

Name of your Pediatrician: _____ Phone Number:_____
When was their last visit: _____

Current Height/Length:_____ Current Weight:_____

Reason for today's office visit:_____
When did it begin:_____
Please explain symptoms or presentation of this condition:

_____

_____
What methods or remedies have you tried:_____
Were they successful:_____
Have you consulted with your Pediatrician or a Specialist for this reason? _____
If Yes, Who: _____
Current Medications or Supplements:_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____**Date**_____

The Pregnancy Process

During the pregnancy process, did the mother:

☐ Take medications? Type _____

☐ Smoke or consume alcohol or drugs? _____

☐ Experience any illness? Type _____

☐ Undergo a lot of stress? _____

☐ Receive ultrasounds or other radiation_____

The Birthing Process

Birthplace: ☐ Home ☐ Hospital ☐ Birthing Center

Type of Birth: ☐ Vaginal ☐ C-Section ☐ Cephalic (head first) ☐ Breech (feet first)

Procedures: ☐ Forceps ☐ Vacuum Extraction

Birth Assistants: ☐ M.D. ☐ Midwife ☐ Doula

What was the child's gestational age at birth? _____

How long did labor & delivery last? _____ hours

How long did you push? _____hours

What was the child's birth weight? _____

How many inches long?_____

Final APGAR score:_____

What was the mother's position during labor? ☐ Back ☐ Side ☐ Sitting ☐ Standing

Did the mother have an episiotomy? ☐ Yes ☐ No

Was labor chemically induced? ☐ Yes ☐ No

Was your child Fed ☐ Breast Milk ☐ Formula ☐ Cow's Milk

Were any drugs administered during the labor process (IV, epidural)? ☐ Yes ☐ No

Was your child subjected to any of the following?

- ☐ Silver Nitrate eye drops
- ☐ Incubation (how long?) _____
- ☐ Vitamin K injection
- ☐ Hepatitis injection
- ☐ Separation from mother (how long?) _____

Vaccinations

Have you chosen to vaccinate your child? ☐ Yes ☐ No

Is your child on the recommended vaccine schedule or on a delayed schedule:_____

Please check all vaccinations received: ☐ DPT ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Flu ☐ Other_____

Describe any reactions to the vaccine(s): _____

Growth and Development

At what age did your child perform the following:

Follow an object_____ Respond to sound_____

Hold up head_____ Vocalize_____

Sit unassisted_____ Teethe_____

Crawl_____ Walk _____

Prior accidents or trauma

Is your child accident-prone? _____

Has your child:

Been hospitalized/surgery? ☐ No ☐ Yes: _____

Had a severe fall? ☐ No ☐ Yes: _____

Been in a car accident? ☐ No ☐ Yes: _____

Any child traumas resulting in bruises, fractures, or stitches? _____

Social History

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any? _____

Approximate hours of playtime each week _____

Any sports participation and age began? _____

Do you feel that your child's social and emotional development is normal for their age? (Please explain) _____

Average hours of sleep per night:_____

Any night terrors, sleep walking, difficulty sleeping? _____

Is a school backpack used? (Heavy or Light) _____

Dietary History

Does your child consume?:

- ☐ fruits (organic is best)
- ☐ vegetables (organic is best)
- ☐ lean meats and fish
- ☐ nuts
- ☐ omega 3 fatty acid supplement
- ☐ probiotics
- ☐ caffeine
- ☐ soda
- ☐ sugar
- ☐ artificial sweetener
- ☐ fast food
- ☐ processed foods

Health History

Has your child experienced any of the following?

- ☐ vision problems
- ☐ pink eye
- ☐ constipation
- ☐ headaches
- ☐ ear problems
- ☐ asthma
- ☐ sleeping difficulty
- ☐ tubes in the ears
- ☐ colic
- ☐ irritability
- ☐ attention problems
- ☐ hyperactivity
- ☐ skin problems
- ☐ frequent colds
- ☐ bedwetting
- ☐ breathing problems
- ☐ digestive problems
- ☐ other_____

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to de ne situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its sta. I authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others. This is effective as of April 14, 2003 and remains in effect until further notice. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Signature_____ Date_____

Insurance Policy

1. The privilege of insurance is conditional on receiving all of the necessary information to process claims.
2. Deductible payments must be made directly to Align Chiropractic Wellness Center for chiropractic services rendered until deductible is met.
3. All co-payments are due at the time of service. If co-insurance payments are indicated on an Explanation of Benefits, the co-insurance is due at the time of notification.
   A **co-payment** is the amount an insurer may require to be paid per visit out- of- pocket from the subscriber (patient). A **co-insurance** is a percentage amount of the office fee to be paid by the subscriber (patient) to the provider,
4. Align Chiropractic Wellness Center, LLC will verify benefits at the patient's request. Verification of benefits is not a guarantee of payment for services.
5. The office will submit insurance claims directly to your insurance company.
6. The insurance policy is a contract between the patient (subscriber) and the insurer. If our office (the provider) has difficulty with your insurer we will require your assistance to obtain details and information. If information is not forthcoming then the privilege of accepting assignment will be terminated.
7. There is no promise of payment by an insurance company made by this office. Any services not paid by the insurance company will be transferred to the patient. As reimbursement rates and coverage of policies tend to vary from month to month, we cannot be responsible for changes in your coverage.
8. It is the goal of the office to provide you with the finest quality chiropractic care possible. However, insurance policies accommodate only symptom care and corrective care. <u>They do not cover maintenance care.</u> Care beyond correction of posture or symptom care is frequently considered maintenance by insurers. This will become patient responsibility for payment.
9. Certain insurers may reject claims or coverage stating a lack of medical necessity or no coverage for children or certain diagnosis. The patient will then be held responsible for these unpaid charges.

Signature_____ Date_____