TODAY DATE ____ - ____ - _____ **IN _____:_____ A / P**

AWAKEN CHIROPRACTIC

NEW PEDIATRIC PRACTICE MEMBER APPLICATION (-12yoa)

PATIENT DEMOGRAPHICS

Childs Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Guardian #1 Name: _____ DOB____/____/____ Cell Phone: _____

E-mail: _____ SS#: _____

Guardian #2 Name: _____ DOB ____/____/____ Cell Phone: _____

E-mail: _____ SS#: _____

Who is responsible for this bill? _____

Pediatrician/Family MD _____City/State _____ Phone _____

Last Visit: _____/_____/_____ Reason for visit:_____

Whom may we thank for referring you? _____ Other: Google / Facebook / Walk-In / Lunch & Learn / Public Event

Has your child seen a chiropractor before? Yes / No Chiropractor's Name: _____ Dates: _____to_____

Circle best <u>days</u> for adjustments: M T W TH *Circle best <u>times</u> for adjustments:* 10am 11am 12pm 3pm 4pm 5pm 6pm

MESSAGING PREFERENCES

Awaken Chiropractic will at times make calls or send texts that will include but is not limited to confirming appointments, alerting the practice member of missed appointments, giving the practice member updates, and to discuss the practice member's case or concerns.
Please <u>check</u> one of the following. If neither are checked Awaken Chiropractic will leave messages and text the numbers provided.

[ ] I give Awaken Chiropractic permission to text me and leave a detailed voicemail at the numbers on my form.

[ ] Please only leave a basic voicemail if unable to reach me.

<u>Preferred</u> Communication Style: Call Text E-Mail Best time to contact you if necessary: _____

MEDICAL INFORMATION (HIPAA) RELEASE FORM

Please **<u>initial</u>** one of the two options. This Release of Information will remain in effect until terminated by me in writing.

[ ] My information is **not to be released** to anyone.

[ ] I **authorize** the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to: Name: _____ Name: _____

CONSENT AGREEMENT

I understand that I am directly and fully responsible to **Awaken Chiropractic** for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____	_____	_____	_____	_____
Guardian's Name	Guardian's Signature	Date	HR #	TM Initial

JDD, DC 5/2011 modified GOL, DC 3/2022

CHILD'S HEALTH CONCERNS:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____ Specific Condition

Please explain: _____

*If your child is experiencing **Pain/Discomfort** in the neck, mid-back, or low back please identify **where and for how long***

_____

_____

1. **When did the** Problem most recently begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? Explain: _____
3. Any **bowel or bladder** problems since this problem began? Explain: _____
4. Any problems preforming daily activities? Explain: _____
5. Have you seen any **other doctors** for this problem? ___No ___Yes

   Doctor's Name: _____ Dates: _____

   What were the results? _____
6. Please list any **medication taken** for this problem: _____
7. The condition is currently: ☐ Improving ☐ About the Same ☐ Worsening ☐ On & Off
8. Please outline any injuries or car accidents your child has sustained:_____

   _____
9. **Briefly explain your child's birth**. Were there any interventions (C-section, forceps, etc)? Any complications? Labor time?

   _____

   _____
10. **Quadruple Visual Analog Scale (QVAS)**: Please circle the number that best describes your child's condition.

#1 Condition: _____	**0 = NO PAIN**										**10 = WORST PAIN EVER**
1. How would you rate the level of your pain RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
2. What is your TYPICAL or AVERAGE pain level?	0	1	2	3	4	5	6	7	8	9	10
3. What is your pain level at its BEST?	0	1	2	3	4	5	6	7	8	9	10
4. What is your pain level at its WORST?	0	1	2	3	4	5	6	7	8	9	10

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply:*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Allergies

_____	_____	_____	_____	_____
Guardian's Name	Guardian's Signature	Date	HR #	TM Initial