



Northwoods Family Chiropractic

337 Superior Ave. Crystal Falls MI 49920

Phone: 906.874.0111 Fax 906.874.0112

northwoodsfamilychiropractic.com

Practice Member Information

File _____

Child's Name: _____ M _____ D _____ Y _____

Parent's/Guardian's Names: _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ May we leave a message? Yes No

Parent's Cell Phone: _____ May we leave a message? Yes No

Parent's Work Phone: _____ May we leave a message? Yes No

Parent's Email: _____

May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)

How did you hear about us? _____

Height (of child): _____ Weight (of child): _____ Birth Date: M _____ D _____ Y _____ Age: _____ Sex: M F

Siblings and ages: _____

Previous Chiropractic Care? Yes No

Emergency Contact

Name: _____ Relationship to child: _____

Phone number: _____ Alternate phone number: _____

Family Doctor

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

May we communicate with your family doctor regarding your child's care if necessary? Yes No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

- He/She is continuing ongoing care from another chiropractor.
- I recently had my spine checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He/She has a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.



Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system in a condition called **Vertebral Subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's **ability to heal**.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive / Slow Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Slow or Absent Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Asymmetrical Crawling or Gait
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Challenges
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Torticollis / Head Tilt	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds / Croup	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Feeding on One Side	<input type="checkbox"/>	<input type="checkbox"/>	Night Terrors
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tip Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Regression of Milestones
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Red, Swollen, Painful Joint	<input type="checkbox"/>	<input type="checkbox"/>	Tremors / Shaking
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>	Autism / PDD

Do you have a specific concern that brings you in?

- No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.
 Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint?

- No if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? No Yes _____

Has your child ever experienced this complaint before? No Yes _____

Did they receive any treatment at the time? No Yes _____

Has your child had x-rays in relation to the current complaint? . . No Yes _____

Prenatal Profile

Adopted Prenatal history unknown Birth history unknown

Complications during pregnancy: No Yes (Brief description) _____

Ultrasounds during pregnancy: No Yes, if so, how many? _____

Medications during pregnancy: No Yes _____

If so which ones and how often? (include OTC): _____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: No Yes _____

Birth Experience

Location of Birth: [] Home [] Hospital [] Birthing Centre [] Other
Birth Attendants: [] Doula [] Midwife [] GP [] OB [] Other
Medications during labor / delivery (including IV antibiotics) [] No [] Yes
Was Pitocin used to induce / speed up labor? [] No [] Yes
Were your membranes ruptured by a medical professional? [] No [] Yes
Was your child at anytime during your pregnancy in an intra-uterine constricting position? [] No [] Yes [] Unsure
If yes, please describe: [] Breech [] Transverse [] Face / Brow presentation
Was your delivery vaginal or C-section? If it was a C-section, was it planned or emergency?
If it was vaginal, was the baby presented: [] Head [] Face [] Breech
Were any of the following interventions used during delivery? [] Forceps [] Vacuum Extraction [] Other
Were there any complications during delivery? [] Yes [] No
If yes, please specify:
How long was the labor from the first regular contractions to the birth? Hours
How long was the second stage (the pushing phase) of the labor? Hours
Was the baby born with any purple markings / bruising on their face or head? [] No [] Yes
Any concerns about misshapen head at birth? [] No [] Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? w d / Birth Weight: lbs oz / Birth Length: Inches
If known, APGAR scores at: 1 minute /10 5 minutes /10
Was the baby ever administered to Neonatal Intensive Care? [] No [] Yes
If yes, for how long and why?
Was any medication given to the baby at birth? [] Yes [] No [] Unsure
If yes, what medication and why?
Was your child exclusively breastfed? [] No [] Yes months
Was your child breastfed + formula fed? [] No [] Yes months
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? [] No [] Yes
What age did you introduce solid foods to your child? months
Did you introduce cereal or grains within your child's first year? [] No [] Yes
Did/Do you practice attachment parenting methods:
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) [] No [] Yes
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
[] No [] Yes, Which ones?

Physical Traumas

Has your child ever fallen from any high places? [] No [] Yes
Has your child ever been involved in a motor vehicle accident or near miss? [] No [] Yes
Has your child been seen on an emergency basis? [] No [] Yes
Has your child broken any bones? [] No [] Yes
Has your child had any previous hospitalizations? [] No [] Yes
Has your child had any previous surgeries? [] No [] Yes
Does your child spend time using a tablet, computer or video games? [] Never [] Rarely [] Daily [] Several hrs/day
Does your child watch tv? [] Never [] Rarely [] Daily [] Several hrs/day
Does your child exercise? [] No [] Daily [] Weekly [] Seasonally
Does your child play contact sports? [] No [] Daily [] Weekly [] Seasonally
Does your child sleep on their [] Back [] Belly [] Sides (Both, Right, Left)
Does your child carry a back pack? [] No [] Yes
Does it weigh less than 15% of their body weight? [] No [] Yes
Do they wear their back pack on 2 shoulders? [] No [] Yes [] Sometimes
Does your child show excessive or uneven shoe wearing out? [] No [] Yes
Does your child wear custom orthotics?
[] No [] Yes, For what purpose?

Chemical Stressors

Have you chosen to vaccinate your child? [] No [] Yes, on a delayed or selective schedule [] Yes, on schedule

Reason for vaccination: [] Informed decision [] Didn't know I had a choice [] It was recommended

Reaction(s) to vaccination: [] Fever [] Welp at injection site [] Rash [] Diarrhea [] Fatigue [] Prolonged Cry [] Seizures [] Developmental Regression [] Other

Does your child receive annual flu shots? [] No [] Yes (informed decision) [] Yes (recommended by MD)

Has your child been exposed to antibiotics? [] No [] Yes

If yes, how many doses in past 6 months? Reason

Were probiotics used at the same time as antibiotics? [] No [] Yes

Has your child been exposed to medications, including OTC: [] No [] Yes

If yes, which ones?

If yes, how many doses in past 6 months? Reason

How many glasses of water/day does your child have? [] 0 [] 1-3 [] 4-6 [] 7-9 [] 10+

How many glasses of cow's milk, juice and soda/day does your child have: [] 0 [] 1-3 [] 4-6 [] 7-9 [] 10+

Does your child eat gluten? [] No [] Yes [] Trying to eliminate from diet

Does your child eat dairy? [] No [] Yes [] Trying to eliminate from diet

Does your child eat refined sugars (white sugar), white bread and pasta? [] No [] Yes [] Trying to eliminate from diet

Does your child eat boxed/frozen foods? [] No [] Yes [] Trying to eliminate from diet

Do you choose organic foods? [] No [] Yes If yes, which: [] Veggies [] Fruits [] Meats [] Grains [] All

Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? [] No [] Yes

Does your child follow any other dietary restrictions? [] No [] Yes

Any food/drink allergies, sensitivities, intolerances? [] No [] Yes

Is your child exposed to second hand smoke? [] No [] Yes

Does your child take a probiotic daily? [] No [] Yes: CFU's/day

Does your child take vitamin D3 daily? [] No [] Yes: IU's/day

Does your child take Omega 3 Fish Oils daily? [] No [] Yes: mg/day [] Capsule [] Liquid

Other supplements or homeopathics?

Goals & Consent

Do you feel your child is developmentally appropriate for their age:

Intellectually: [] Yes [] No

Emotionally: [] Yes [] No

Physically: [] Yes [] No

What is your primary goal for your child at our clinic?

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I being the parent or legal guardian of

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

Consenting Adult's Signature

Date

Northwoods Family Chiropractic

202 W Adams Street
Iron River, MI 49935
906-265-9000

Informed Consent

Medical doctors, chiropractic doctors and osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____ on _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments and/or massage therapy involving movement of the joints and soft tissues. Physiotherapy and exercises may also be used.

Although spinal manipulation/adjustment and/or massage therapy is considered to be one of the safest, most effective forms of therapy for muscular skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fracture/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this clinic will proceed with caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

No treatment: I understand the potential risk of refusing or neglecting care may include increase pain, scar/adhesion, formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology, The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient/guardian

Signature of witness

Date and time

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Chiropractic (Please initial one of the following options and sign below.)

I acknowledge that I have read the Notice of Privacy Practices from Northwoods Family Chiropractic prior to signing this document. Northwoods Family Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of the bills, or the performance of health care operations of Northwoods Family Chiropractic. The Notice of Privacy Practices for Northwoods Family Chiropractic is also provided on request at the main administration desk of the practice. This Notice also describes my rights and Northwoods Family Chiropractic's duties with respect to my health information.

Northwoods Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I wish to receive a paper copy of Privacy Notice.

I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

X _____
Signature of Patient/Guardian Date

X _____
Witness (Office Staff) Date

Northwoods Family Chiropractic
202 W Adams St
Iron River, MI 49935
906-265-9000

CONSENT TO TREAT A MINOR

I, the undersigned parent and/ or guardian of _____,

Date of Birth _____ / _____ / _____, S.S. # _____ - _____ - _____,

a minor child, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary, with out parental supervision.

Parent or legal guardian name (please print)

Parent or legal guardian's signature

Witness's signature

Date (effective on file or unless revoked earlier in writing)

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- Health and accident insurance polices are and agreement between patients and their insurance carriers;
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company
- Any amount that is authorized to be paid directly to this office will be credited to my account upon receipt, I permit this office to endorse insurance payments to be applied to my account;
- All services rendered to me are charged directly to me and that I am personally responsible for the payment of my account
- It is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made with our billing specialist.

Financial Policy

Insurance Coverage

Welcome to Northwoods Family Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your \$100 at the beginning of the year. Our clinic will call your insurance to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determination.

Payments

In order to help you determine your responsibility toward payment for services, please ready the following, and initial your preference for the method of payment on your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C _____ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Returned Check/Insufficient Funds Policy

It is the policy of Northwoods Family Chiropractic to assess a \$20.00 returned check/insufficient funds fee to patients who have a returned check due to insufficient funds/other reasons or insufficient funds when running a stored credit card on file. More than 2 repeat occurrences will result in the inability to pay in this manner.

_____ My initials here indicate that I understand the above return check policy.

I understand that all health services rendered to me and charged to me are my person financial responsibility. I understand and agree to the conditions of the policy.

Signature

Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____

DOB _____ authorize _____

to release the following medical information to Northwoods Family Chiropractic any and all medical records including imaging and reports, i.e. x-rays, MRI, CT, etc.

Please send films to the following address:

Northwoods Family Chiropractic, P.C.
202 W. Adams St.
Iron River, MI 49935

Please fax records to the following phone number:

Northwoods Family Chiropractic (Iron River)
(906) 265-9009

This information is being released for diagnostic and treatment purposes only and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective until it is revoked by me at any time by providing notice in writing to the above named party.

Patient Date: _____

Parent/Guardian Date: _____

Witness