Pediatric
Infants & Toddlers

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	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	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 constraining 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? ☐No ☐Yes
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 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? _____

Child Health History *(Answer only those which are applicable)*

How many hours does your baby sleep between feedings? _____ Day _____Night
Does your child have a preferred sleeping position? ☐No ☐ Yes _____
Does your child have any feeding difficulties? ☐No ☐Yes _____
Is your child currently being breast fed? ☐Yes: exclusively breastfed ☐formula supplemented ☐No
If no, how long was the baby breast fed? _____ weeks/months
Does your child have a one-sided breast preference? ☐No ☐Yes If yes, Prefer Left or Right _____
Does your child frequently spit up after feeding? ☐No ☐Yes
Does your child cry often? ☐No ☐Yes If yes, approximately how many hours per day? _____
Does your child pass a lot of intestinal gas? ☐No ☐Yes
Does your child frequently arch his/her head and neck backwards? ☐No ☐Yes
Has your child shown any sensitivities to foods either in your diet or their own? ☐No ☐Yes _____
Is your child exposed to cow's milk/dairy? ☐No ☐Yes, formula ☐Yes, directly ☐Yes, I drink it and breastfeed.

Developmental History

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_____

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 ☐Welt 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 _____,
(print name of consenting adult) (print name of minor)

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 lightening. 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 tat 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 join 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 herby 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

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 deducible 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 b 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

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.

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.

_____ Date: _____
Patient

_____ Date: _____
Parent/Guardian

_____
Witness