An Even Vída

CHILD REGISTRATION AND HISTORY

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Applied Kinesiology & Chiropractic Wellness

Please complete this Patient Registration and History Form, as well as any other requested documents.

Patient Background

Child's Name: ______________________________ (First Middle Last) Date of Birth: _________ Age: ___ M/F Ht: _____ Wt: ____

Home Address: ____________________________________ City/Sate: ____________________ Zip _______

Phone: _(____)__________ Guardian Email: _____________________ Best Way To Contact Guardian? ___________

Who can we thank for referring you or how did you hear about us? ____

I hereby Authorize and consent to the examination and care of my child, by the Doctor(s) of Chiropractic.

Parent/Guardian Signature: ______________________________ Date: ____________

Why Are You Seeking Treatment, current condition, or focus of care?

Please briefly describe: ____

Date Primary Reason or Symptoms Began: _______________ Is this a result of an accident or injury? _____________

What do believe is going on or would help? ____

____

Please indicate your exposure to the following therapies:

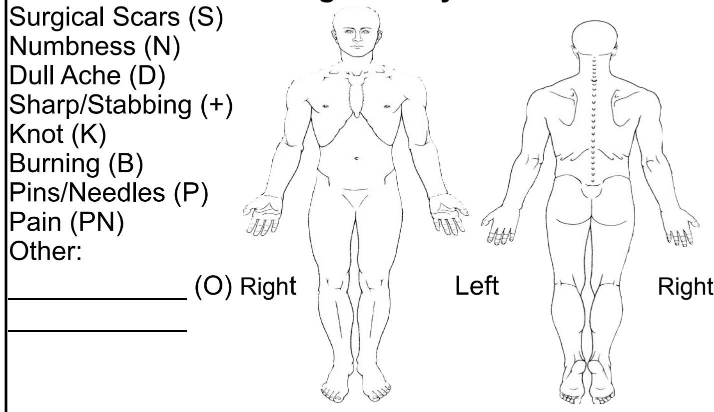
Chiropractic Care:	Y	N	Massage Therapy:	Y	N
Acupuncture:	Y	N	Applied Kinesiology	Y	N
Nutrition/Supplementation:	Y	N	Osteopath Manip.	Y	N
Medicinal Herbs:	Y	N	Other: ____________________		
Homeopathy:	Y	N	____________________		
			If yes, date of last visit: _________		

What are your health goals?

___ Remove/Reduce Pain
___ Gain more energy and stamina
___ Fix the cause of the problem
___ Restore health and reduce illness
___ Achieve optimal wholeness

Indicate any of the following areas if applicable in the chart with following letter/symbol

Surgical Scars (S)
Numbness (N)
Dull Ache (D)
Sharp/Stabbing (+)
Knot (K)
Burning (B)
Pins/Needles (P)
Pain (PN)
Other:
____________ (O)
____



Patient Background Continued

1. Is child currently under any other care? Y/N If so, please explain/describe: ______________________________
____
2. Since onset of primary reason for being here, it has gotten: Worse Same Better
3. Does it change (get better or worse) in: No Pattern Morning Midday Afternoon Night
4. Do you have any Emotional Stressors that you believe may be related to or affecting your status? Describe:_____________
____
5. Have you been diagnosed with/by a diagnosing professional? Y/N If so please list:______________________________
____
____

6.InitiatingFactors: ____
7. Aggravating Factors:____
8. Relieving Factors:____
9. How does this affect your child's function and daily activity?___________________________________

Family Diseases (Past & Present) G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self

______Alcoholism/Drug Abuse
______Anemia
______Cancer:____________
______Cold Sores
______Deep Vein Thrombosis
______Detached Retina
______Diabetes
______Diverticulitis/IBS
______Eczema
______Emphysema
______Epilepsy
______Goiter
______Gout
______Heart Disease
______Hepatitis
______HIV/AIDS
______Miscarriage
______Mumps
______Pleurisy
______Pneumonia
______Polio
______Rheumatic Fever
______Seizures/Fainting
______Stroke
______Tumors
______Ulcers
______Vaccination Reaction
______Other: ____________
____

Medications, OTC, Supplements	Reason For Taking	How Long or Date Started

Patient Birth History
Date of Last Check-up: _______ Hospital/Birthing Center: ___Home ___Medical ___ Midwife Gestation: ___ wks
Was Birth Assisted: Y/N If Yes, how? Forceps Vacuum Extraction C-Section Induced Labor Other:_________
Were medications given to Mom at birth? Y/N If Yes, what? _________________
Birth Weight: ______ Birth Length:_____
Was the delivery normal? Y/N If No, what complications were there at birth? ___________________________________
Duration of birth? _____ Any evidence of trauma during birth?___ Bruises ___ Stuck in birth canal ___ Odd Shaped Head ___ Excessively long birth ___ Respiratory Depression ___ Cord around neck ___ Other: __________________________

During Pregnancy Did Mom:
1. Take Supplements/Vitamins? Y/N If Yes, what? _____________
2. Receive Ultrasounds Y/N If Yes, how many?___
3. Take any medications? Y/N If Yes, what? _____________
4. Smoke? Y/N 5. Drink Alcohol? Y/N
6. Receive invasive procedures (i.e. amniocentesis, CVS, etc)? Y/N If Yes, what?_________________________________
7. Have any falls or accidents? Y/N If Yes, please describe: ____

Growth & Development
What age did child: Respond to Sound? _____ Follow an object? _____ Hold head up? _____ Vocalize? _____
Sit alone? _____ Teethe? _____ Crawl? _____ Walk? _____ Sleep through night? _____ Solid Foods? _____
Was your child breast fed? Y?N If Yes, how long? _____ What age was formula introduced? ______ Cow's Milk?______
Did your child receive vaccinations? Y/N If Yes, which ones?____
Did your child react to them? Y/N Any pets at home? Y/N If Yes: _______________ Any smoker's at home? Y/N
Has your child had antibiotics? Y/N If Yes, how many courses and why?____
Any difficulty with lactations? Y/N Any problems with bonding? Y/N
Does your child seem normal to you? Y/N
Has child had any major falls since birth? Y/N If Yes, did the child need stitches or did it cause a fracture? _____________
Any hospitalizations? Y/N Describe: ____________________________
Any difficulty sleeping (nightmares, bedwetting, sleepwalking) Y/N If Yes, Specify: _____________________________
Does child attend day care? Y/N At what age? ____
Any behavior problems? Y/N If Yes, Describe:____
Ear Infections? Y/N How many? _____ Colic? Y/N Asthma? Y/N Diabetes? Y/N Attention Deficit or Hyperactivity? Y/N
Does your child play sports? Y/N If Yes, what? _____________ What age began? ______ Any injuries from sports? Y/N
Any auto accidents? Y/N If Yes, ________________________ Average number of hours of TV/Computer per week? _____

Anything else that may or may not be pertinent or related to what's going on, but that you would like to communicate to the Doctors? ____
____

Notes To Be Completed By Doctor:

HIPAA & CONSENT

We would like you to know how our office will be using your information and the rights that you have as a patient here regarding your records. Before we begin with your healthcare needs we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow An Even Vída Applied Kinesiology to use their patient information for the purpose of treatment, payment, and health care operations.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their patient information. Our office will not release any of your records without your written permission

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the consent has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to An Even Vida Applied Kinesiology to assure that your records are not readily available to those who do not need them.

6. If the patient has a complaint about privacy of records please see Dr. Eubanks.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations the chiropractic physician has the right to refuse care.

Patient Billing Information & Consent for Professional Services

I understand that all payments are due to An Even Vída Applied Kinesiology at the time services are rendered. All bills are due and payable in full at date of service.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. *An initial visit for a child under the age of 10 years old (not including age 10) usually consists of a consultation ($50) and exam ($99), for further pricing contact the office.*

An Even Vída Applied Kinesiology is not responsible for submitting claims to any insurance entity included but not limited to health, auto, worker's compensation or personal injury. If I intend to submit receipts acquired at An Even Vída Applied Kinesiology to an insurance entity I must notify the front desk before payment.

As a courtesy to our patients who are waiting for available appointments we ask that you give 24 hours notice of cancellation so that time can be given to another. If 24 hours notice is not given you will be responsible for the full scheduled office visit fee.

If copies of medical records are needed, a charge of $10.00 for copy charge and an additional 10 cents per page over 15 pages will be billed to you.

I have read and understand how my patient information will be used and how the payments are due, and I agree to these policies and procedures.

______________________________ ______________

Signature Today's Date