Start time:

T, C/D, E, X

RENEGADE CHIROPRACTIC

New Practice Member Application

Name: _____ Date of Birth: _____ Age: _____ ◯ M ◯ F

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

Phone Number _____ Weight: _____ Height: _____

Guardian(s) Name: _____ Relationship: _____

Siblings: _____ Child's Social Security #: _____

Whom may we thank for referring you? _____

Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine, and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Reason for pursuing care: ◯ Maintenance ◯ Improved health ◯ Problem _____

Have you ever seen other doctors for these conditions? ◯ Yes ◯ No If Yes: ◯ Chiropractor ◯ Medical doctor ◯ Other _____

Who? _____ When? _____ Results? _____

Name of pediatrician _____ Last visit? _____

Present perscription drugs/dosage? _____ Past perscription drugs/dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.:

_____

Birth intervention: ◯ Forceps ◯ Vacuum extraction ◯ Caesarian Section ◯ Other

If Caesarian Section, was it: ◯ Emergency OR ◯ Planned

Birth weight: _____ Birth length: _____ APGAR scores _____

Breast fed ◯ Yes ◯ No Formula fed ◯ Yes ◯ No How long? _____ Type: _____

Food allergies or intolerances: ◯ Yes ◯ No If yes, please list: _____

Please Mark "P" For In the Past or Past Mark "C" For Currently Have:

☐ Ear Infections	☐ Digestive Issues	☐ Bed Wetting	☐ Car Accident: when?
☐ Food Allergies	☐ Growing/back pains	☐ Headaches	
☐ Environmental Allergies	☐ Colic	☐ Recurring Fevers	☐ Other (list any other health problems)
☐ Seizures	☐ Chronic Colds	☐ Temper Tantrums	
☐ Scoliosis	☐ ADD/ADHD	☐ Asthma	

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to: Respond to stimuli _____ Hold Head Up _____ Walk alone _____

Stand alone _____ Sit up _____ Cross crawl _____

List Restricted Activity	Current Activity Level	Usual Activity Level

Has your child been involved in any sports? ◯ Yes ◯ No List: _____

Has your child been seen by a physician on an emergency basis? ◯ Yes ◯ No Explain: _____

Other traumas not described above _____

Lifestyle

Please check all that apply

Does your child:

☐ Drink water ☐ Take probiotics ☐ Take Vitamins Type: _____

☐ Eat health food products (organic products, etc.)

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Hobbies/interests: _____

Parent/Gurardian Name

Doctor's Signature

Parent/Guardian Signature (If having trouble, feel free to sign when you arrive)

Doctor's Signature Date

Parent/Gurardian Signature Date

Written Consent for a Child

For A Minor/Child, Please Fill Out and Sign Below

Name of practice member who is a minor/child: _____

Guardian signature

Guardian signature date

Relationship to minor/child

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature (If having trouble, feel free to sign when you arrive)

Date

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Renegade Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print name

Date of birth

Signature (If having trouble, feel free to sign when you arrive)

Date