



Date: _____ Child's Name: _____ Birth Date: _____

Age: _____ Grade: _____ Sex: _____ SS # of Guardian: _____ Mother/Father

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

Parent/Guardian 1

Name _____ Email _____

Address, if different _____

Occupation _____ Employer/City _____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent/Guardian 2

Name _____ Email _____

Address, if different _____

Occupation _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Number of Siblings _____ Names and Ages _____

Family Medical Doctor _____

Has child received previous chiropractic care? Yes or No

If yes, when was the last adjustment: _____ Where? _____

How were you referred to our office? _____

HISTORY OF PRESENT ILLNESS:

Reason for your visit today? _____

How long has your child had this problem? _____

What caused it? _____

Have they ever had the same or a similar condition? Yes or No. If yes, when and describe: _____



HEALTH HISTORY:

Has your child ever experienced the following or been diagnosed as having any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Illness accompanied by a high fever | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches (occasional or frequent) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Hypoglycemia (low blood sugar) |
| <input type="checkbox"/> Ear infections/earaches (if so, how many) _____ | <input type="checkbox"/> Trouble with bladder control |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Serious fall or repetitive falls | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies to foods | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chemical insensitivities | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Is child vaccinated? | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Have you declined any vaccines? | <input type="checkbox"/> Neck or back problems |
| <input type="checkbox"/> Adverse reaction to any vaccinations (even if mild) | <input type="checkbox"/> Joint or muscle problems |
| <input type="checkbox"/> If yes, please explain: _____ | |

NEUROLOGICAL/OTHER:

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Other _____ |

CURRENT/PAST MEDICATIONS AND TREATMENTS:

List any SURGERIES that your child has had _____

List any MEDICATIONS that your child is taking or has taken in the past. Names, dosage, frequency.

List any NUTRITIONAL SUPPLEMENTS your child takes (vitamins, herbs, naturopathic remedies, etc.) _____

List any special services that your child is currently receiving at school or privately _____

List any special needs your child has _____

List any treatment that your child is currently undergoing with any health professional _____

FAMILY HISTORY:

List any health conditions of mother/father _____

ACTIVITIES:

What activities/sports does your child participate in _____
Frequency _____



**** THIS PAGE FOR CHILDREN AGES 0 – 12 ONLY ****

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)

Did you ever experience any of the following during your pregnancy?

- | | |
|--|--|
| <input type="checkbox"/> Severe viral infection during the first trimester | <input type="checkbox"/> Alcohol consumption and/or drug use |
| <input type="checkbox"/> Breech position during pregnancy | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Accident or infections | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Severe stress | <input type="checkbox"/> Uncontrolled Diabetes |
| <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Toxemia |

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- | | |
|--|---|
| <input type="checkbox"/> Hospital birth | <input type="checkbox"/> Home birth |
| <input type="checkbox"/> Long and/or difficult labor | <input type="checkbox"/> The delivery was rapid |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Breech birth |
| <input type="checkbox"/> Forceps or vacuum | <input type="checkbox"/> Cord around neck |
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Emergency C-section |
| <input type="checkbox"/> Elective C-section | <input type="checkbox"/> The child was premature (2+ weeks) |

The child was a "blue baby"

Labor was induced. If yes, reason? _____

Medications during delivery. If yes, list (i.e. Epidural) _____

Comments: _____

Newborn History

Weight at birth: _____ Length at birth: _____

Did the child experience any of the following as a newborn?

- | | |
|--|---|
| <input type="checkbox"/> Required resuscitation/oxygen | <input type="checkbox"/> Distorted skull |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty latching/sucking |
| <input type="checkbox"/> Poor sleeper | <input type="checkbox"/> Formula fed |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Feeding (___ breast or ___ bottle) |
| <input type="checkbox"/> Immunizations in hospital | If breast fed, how long _____ |
| If yes, specify vaccine: _____ | |

Developmental History

Does your child have any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours) | <input type="checkbox"/> Did not crawl on all fours |
| <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Appears clumsy |
| <input type="checkbox"/> Difficulty learning to read | <input type="checkbox"/> Difficulty with writing |
| <input type="checkbox"/> Difficulty using utensils | <input type="checkbox"/> Difficulty buttoning clothing |
| <input type="checkbox"/> Difficulty tying shoes | <input type="checkbox"/> Difficulty or awkward with walking/running |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> Difficulty sitting still or paying attention |

Age of child when he/she sat _____ crawled _____

How long did your child crawl (in months): _____

At what age did your child start to walk unassisted: _____



AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors at Great Lakes Chiropractic to evaluate and treat my son/daughter as she deems necessary.

I understand and agree to allow Great Lakes Chiropractic to use Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING CARE

DATE

WITNESS

DATE



STANDARD CONSENT

When a patient seeks Chiropractic health care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body’s natural ability toward self-healing. Our only method is specific adjusting to correct vertebral subluxations.

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

- | | | | |
|--------------------|----------|-----------|-----------------|
| pain | burns | swelling | sensory changes |
| soft tissue injury | bruising | bleeding | stroke(CVA) |
| discoloration | fracture | dizziness | inflammation |
| disc injury | nausea | weakness | soreness |

By signing below, I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

SIGNATURE OF PARENT OR GUARDIAN

DATE



FINANCIAL POLICY

INSURANCE: You should be prepared to present your current insurance card. All claims will be submitted to your insurance carrier unless otherwise specified. We do not have a way to access the terms of your insurance policy and therefore cannot quote coverage or benefit levels or guarantee that your insurance company will cover the services we have provided. If you have questions, please call your insurance carrier directly.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Great Lakes Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Great Lakes Chiropractic will be credited to my account. However, I agree that I am personally responsible for all services not paid for by my insurance. I also am responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

COPAYS: Co-payments are due *on the day of your appointment*.

SECONDARY/SUPPLEMENTAL INSURANCE: Please inform us of any secondary insurance you may have.

MEDICARE: We do accept Medicare. Medicare covers manual manipulation of the spine *only*. All other services are NOT covered. These services include, but are not limited to: x-rays, examinations and therapies. You are required to pay any deductible and remaining balance after Medicare processes your claim.

WORKER'S COMPENSATION/PERSONAL INJURY: Please inform us immediately if you are injured on the job or are involved in an accident. We will work with you to manage your care and submit your fees.

CASH RATE/NO INSURANCE: For patients who carry insurance in which we are not in-network or for patients who do not wish to submit claims to their insurance company, we offer a cash-payment office visit. If this is something you may be interested in, please ask at the front desk. This charge will be due at the time of your appointment.

STATEMENTS: After your insurance company has processed your claims, you will receive a statement from us for the unpaid balance. Your payment is due within 30 days of the statement date. If you are unable to pay your balance in full prior to the due date, please call our billing office at 763-777-9313 to set up payment arrangements. **Late Fees may be charged to your account if timely payment is not made.**

MISSED APPOINTMENT POLICY: Your time is important, as is ours. If you must cancel or reschedule an appointment, please make every effort to do so at least 24 hours prior to your appointment time. **If you do not call to cancel/reschedule and you do not come in for your appointment, a \$40.00 fee will be charged to your account.**

PAYMENT OPTIONS: We accept cash, checks, debit card, and credit card.

I have read and understand the Financial Policy of Great Lakes Chiropractic. I understand that I am responsible for all services not paid for by my insurance including deductibles, copayments, or non-covered services.

SIGNATURE OF PARENT OR GUARDIAN

DATE



Authorized people who have access to my information

I authorize Great Lakes Chiropractic to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people.
(ex: spouse, parent, children)

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

This is valid until revoked or changed by written communication.

SIGNATURE OF PARENT OR GUARDIAN

DATE

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**CONSENT TO TREAT A MINOR WITHOUT PARENT/GUARDIAN PRESENT**

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. I authorize Great Lakes Chiropractic and its personnel to administer chiropractic care as deemed necessary to:

\_\_\_\_\_  
NAME OF MINOR

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
**PARENT OR GUARDIAN (Please Print)**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARENT OR GUARDIAN SIGNATURE**