Health From Within Family Wellness Center

1818 Marron Road, Suite 103
Carlsbad, CA 92011
760-385-8352

Patient Name _____ Gender: M F Date of Birth _____

Social Security # _____ Height _____ Weight _____

PEDIATRICIAN INFO:

Name _____ Phone_____

GUARDIAN INFORMATION:

Name _____ Relationship to Child _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Best number and time to reach you? _____

E-mail _____

Address_____ City _____ State_____ Zip code_____

To better serve you, please answer the following questions:

Check off the following symptoms or disorders you have and CIRCLE the ones that affect you the most:

Headache/Migraines	Neck Pain	Hip Pain (right or left)	Chemical Stress
Allergies	Shoulder Pain (right or left)	Knee pain (right or left)	Physical Stress
Chest/Rib Pain	Elbow Pain (right or left)	Ankle Pain (right or left)	Emotional Stress/Anxiety
Dizziness	Wrist Pain (right or left)	Muscle Stress	Attention Disorders
Ear Aches	Scoliosis	Constipation	Sciatica
Asthma	Low Back pain	Hyperactivity	Numbness/Tingling
Frequent Colds/Flu	Mid-Back Pain	Arthritis	Leg pain (right or left)
Heartburn/Reflux	Disc Problems	Arm pain (right or left)	Vertigo
Low Energy/Fatigue	Insomnia	Depression	Ulcers
Weight Gain	Ringing/Buzzing in Ears	Bed Wetting	Autoimmune Disease
Loss of Memory	High Blood Pressure	Menstrual Problems	Diabetes
Excess Gas/Bloating	Low Blood Pressure	Thyroid Trouble	Swollen Ankles
Multiple Sclerosis	Fibromyalgia	Circulatory Problems	Skin Conditions/Acne
High Cholesterol	Shortness of Breath	Nausea	Diarrhea
Bladder Problems	Cancer	Vascular Disorder	Urinary Difficulty
Digestive Problems	Heart Condition	Immune System Disorder	Sinus Trouble
Infertility	Kidney Disease	Mood Swings	Osteoporosis

Other:_____

What is your chief concern regarding your child?

_____

_____

Date of onset: _____ Onset speed (circle one): Sudden Gradual Associated with event

Duration of condition/edisode (circle one): Minutes Hours Days Months Years

Pattern of problem (circle one): Constant Intermittent Occasional Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body and everyday activities?

_____

_____

Please use this space to include any other relevant details regarding the conditions cited above.

_____

_____

PREVIOUS TREATMENT

Has your child been treated by a chiropractor for his/her condition or symptoms? YES NO

Name of Chiropractic Doctor _____ Date of most recent chiropractic visit _____

Has your child undergone any other treatment for his/her condition or symptoms? Please elaborate if so.

_____

_____

History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? □ Yes □ No If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? □ No □Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? ____ Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

_____

The father's side? _____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No 3. Take supplements/vitamins? □ Yes □ No

4. Take drugs? □ Yes □ No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? □ Yes □ No If yes, how many?_____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long? _____ weeks months years

At what **age** was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? □Yes □ No If yes, which ones? _____ Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why? _____

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour _____

problems? □ Yes □ No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify: _____

Did your child go to daycare? □ Yes □ No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth

□ Respiratory Depression □ Cord around neck □ Other _____

Any falls/accidents during pregnancy? □ Yes □ No Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? □ Yes □ No Please explain: _____

Does your child play sports? □ Yes □ No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx. Hours spent at play per week? _____ hrs

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Informed Consent:

The chiropractic doctor provides a specialized, non-duplicating health care service which includes detecting and correcting spinal subluxations (a misalignment of one or more vertebrae causing a blockage in nerve flow). It is important to note that the chiropractic doctor cannot diagnose, treat or cure any disease, although the doctors of Health From Within Family Wellness Center are more than happy to work with other types of providers in your health care regimen.

I do hereby authorize the doctors of Health From Within Family Wellness Center to administer such chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments or any other chiropractic procedure, which is advisable and necessary for my healthcare. I shall have an opportunity to discuss all chiropractic care that shall be necessary for my particular case. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated, however, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic doctor. I acknowledge that no guaranties can be made with respect to my treatment, and regardless of the outcome, I shall be responsible for all costs associated with my care.

In considering the amount of chiropractic expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Health From Within Family Wellness Center, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of seven percent (7%) per annum. I further acknowledge and agree that Health From Within Family Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Health From Within Family Wellness Center

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I understand that Health From Within Family Wellness Center has video recording equipment in the office for training purposes and to ensure that I receive the best possible care and experience. By signing below, I give permission to Health From Within Family Wellness Center to video record my office visits. I shall have the option to revoke my consent upon giving written notice to the Office Manager.

Acknowledgement

I have been informed that upon request I can receive a copy of the privacy practices (HIPPA). I am aware that I have an opportunity to discuss my rights to privacy if I please.

Print Name: _____ ***Signature:*** _____ ***Date:*** _____

Additional Terms of Acceptance

We are committed to you, and helping you and your family to understand your health condition. In order to achieve this, the following is our policy regarding going over your x-ray results. Should the doctor determine & your test reveal that you have subluxation, nerve damage or dysfunction, or degeneration (or any other serious conditions on your x-rays), YOUR SPOUSE will be required to attend the immediately next scheduled doctor's visit to discuss your exam/x-ray findings. This is for your own safety and benefit, as we believe that it is crucial to have family support to help with your health.

Additionally, it is important to have your spouse in attendance due to vital nature of what will be discussed, including but not limited to the following:

1. Treatment choices and options.
2. Insurance or other financial arrangements.
3. Supportive home care.

Having your spouse in attendance will also prevent having to go over an x-ray/exam finding more than one time per patient, preventing unnecessary work and minimizing charges and costs to you. The Doctor is willing to contact any employers for excused absence needs. Your cooperation is appreciated.

I have read, understand, and agree to the above additional terms of acceptance.

Name:_____ Signature:_____ Date: _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name: _____ Signature: _____ Date: _____

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: _____ Children: _____ Others: _____