INVIGORATE CHIROPRACTIC

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN
WRITTEN CONSENT FOR A CHILD/MINOR

NAME OF PATIENT WHO IS A CHILD/MINOR _____

I AUTHORIZE DR. KEVIN SCHULTZ AND ALL INVIGORATE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY CHILD/MINOR.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY CHILD/MINOR. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY INVIGORATE CHIROPRACTIC.

_____ _____

DATE GUARDIAN'S SIGNATURE

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) GUARDIAN'S RELATIONSHIP TO CHILD/MINOR

INVIGORATE CHIROPRACTIC

PEDIATRIC INTAKE FORM
Infant – 10 years old
Today's Date:

PATIENT INFORMATION

Child's Name:_____ Parent/Guardian Name:_____
Gender: ☐ Male ☐ Female D.O.B:_____/_____/_____ Age_____
Current Height:_____ Current Weight:_____
Address: _____
City, State, Zip: _____

Other Children's names/ages:
_____

Email: _____ Home Phone: _____
Cell Phone: _____ Cell Provider:_____ ☐Yes! I want to opt for text appt reminders
How did you hear about us? _____
Has your child been adjusted by a chiropractor before? ☐ YES ☐ NO
If yes, reason for those visits: _____
When was the last visit?_____

Is your child receiving care from other health professionals? ☐ YES ☐ NO
If yes, list name and specialty: _____
Who is your family's primary care physician?_____
Contact information:_____

HEALTH HISTORY
Describe the health concern that prompted this visit:_____
When did this concern begin? _____ How did this concern begin? _____

Has this condition: ☐ Worsened ☐ Stayed the same ☐ Been Intermittent
Does this interfere with: ☐ School ☐ Sleep ☐ Daily Routine
What makes this condition worse? _____
What makes this condition better? _____
Has your child seen anyone else for this concern? ☐ YES ☐ NO Type of treatment:_____
Please list any medications taken for this concern:_____

Child's birth was at: ☐ Home ☐ Birthing Center ☐ Hospital OB/Midwife/Physician was:_____
Child birth was: ☐ Natural vaginal with no medications
☐ Vaginal with interventions: ☐ Pitocin ☐Epidural ☐ Pain Medications ☐ Vacuum Extraction
☐ Forceps ☐ IV antibiotics ☐Other:_____

C-Section: ☐ Scheduled ☐ Emergency
☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown
Was your child at any time during your pregnancy in a constrained position?: ☐ YES ☐ NO ☐ UNSURE
If yes, please describe: ☐ Breech ☐ Transverse ☐ Face/Brow presentation
Complications during pregnancy: ☐YES ☐ NO (If yes, describe)_____

Medications during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____
If so, which ones and how often? (include Over-the-counter):_____
_____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____

Birth Weight:_____lbs _____oz Birth Height:_____
Please list all of your child's hospitalizations and surgical history (include year):

_____

_____
Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:
_____

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, 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 – 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?

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Asymmetrical Crawling
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis/Head Tilt	☐	☐	Sleeping Problems
☐	☐	Frequent Colds/Croup	☐	☐	Trouble Nursing	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Seizures
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Tremors/Shaking
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joints	☐	☐	ADD/ADHD
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	Autism
☐	☐	Digestive Issues	☐	☐	Frequent Crying Spells/Colic			

Other:_____

What is your primary goal for your child at our clinic?_____
_____

Our goal is to provide a detailed assessment of your child's current health status and provide you with 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 properly functioning nervous system that is able to function free from interference called subluxation. Dr. Kevin is certified in both pregnancy and pediatrics, is certified in the Webster Technique, and is a member of the International Chiropractic Pediatric Association.

INVIGORATE CHIROPRACTIC

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. **THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.** DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR(S) OF INVIGORATE CHIROPRACTIC DO 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 YOUR NAME HERE DATE

_____ _____

SIGNATURE YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT INVIGORATE CHIROPRACTIC.

_____ _____

SIGNATURE DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDES: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE ADJUSTMENTS, MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND, IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____ _____ _____

PATIENT'S NAME HERE PATIENT SIGNATURE DATE

IF PATIENT IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____ _____

SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP TO MINOR/CHILD DATE

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

INVIGORATE
CHIROPRACTIC

PATIENT INFORMATION - MUST BE COMPLETED BEFORE SERVICES CAN BE RENDERED

NAME: _____
FIRST MIDDLE LAST

PHONE: Home: _____Cell: _____ Work: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE POLICIES AND FEE SCHEDULE

o CONSULTATION & EVALUATION – (new or established patient) – includes one or more of the following: patient history, thermography, surface electromyography, range of motion, motion and/or static palpation, orthopedic and neurological evaluation, leg check: $90
o CHIROPRACTIC ADJUSTMENT – The actual re-alignment of the vertebra performed by handheld instrument: $50
o X-RAYS – Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care: $50 cervical views*, $50 thoracic views*, $50 lumbar views*, and $60 per full spine view.
*These prices include standard AP and Lateral views; the values do not include Oblique views, Flexion/Extension Views, or other views.

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Kevin Schultz, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____
SIGNATURE DATE

INVIGORATE
CHIROPRACTIC

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supportive, open environment.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

SIGNATURE DATE