Confidential Health Information:
Care Chiropractic 134 Executive Drive #3
Lafayette IN 47905
(765) 448-6489

_____
Patient Number
____/_____/_____
Today's Date

_____ _____ ___/_____/___ _____
Last Name Social Security Number Birthdate Age

_____ _____ Male_____Female
First Name Middle Name (Initial) Gender

_____ Married__Single__Divorced_Widowed
Address Marital Status

_____ _____ _____ _____
City State Zip Code Email

_____ _____ _____
Home Phone Cell Phone Best time and place to reach you

Would you like to receive appointment reminders by **email** or **text** ? Cell Carrier: _____
(please see "Acknowledgements" page for text reminder additional terms/conditions)

_____ _____
Employer Occupation

_____ _____
Spouses Name Whom may we thank for referring you ?

_____ _____ ___/___/___
Insurance Carrier Insured's Last Name Birth Date

_____ _____ Self____Spouse___Parent
Member ID Number Group Number Who carries this policy?

If you are covered by additional insurance please indicate : _____

Assignment and Release
I certify that I, and /or my dependent(s) have insurance coverage with _____
And assign directly to Care Chiropractic / Williams Chiropractic Corporation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian, Representative Relationship to Patient

_____ _____
Printed Name of Patient, Parent, Guardian, Representative Date

PEDIATRIC HISTORY FORM

PATIENT NAME:_____ S.S. #_____

ADDRESS:_____ CITY_____

STATE:_____ ZIP:_____ HOME PHONE:_____

BIRTHDATE:____/____/____ CELL PHONE:_____

SEX:_____ WEIGHT:_____ HEIGHT:_____

NAMES OF PARENTS / GUARDIANS:_____

PURPOSE FOR CONTACTING US?

_____

OTHER DOCTOR'S SEEN FOR THIS CONDITION:_____Y_____N, DOCTOR'S NAMES & PRIOR

TREATMENTS:_____

OTHER HEALTH PROBLEMS?_____

FAMILY HISTORY:_____

PREVIOUS CHIROPRACTOR:_____
DATE OF LAST VISIT:___/___/___REASON_____

NAME OF PEDIATRICIAN:_____
DATE OF LAST VISIT:___/___/___REASON:_____
ARE YOU SATISFIED WITH THE CARE YOUR CHILD RECEIVED THERE? Y/ N

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN:
DURING THE PAST 6 MONTHS:_____, TOTAL DURING HIS / HER LIFETIME:_____

NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAD TAKEN:
DURING THE PAST 6 MONTHS:_____, TOTAL DURING HIS / HER LIFETIME:_____

VACCINATION HISTORY:_____

PARENTAL HISTORY:

NAME OF OBSTETRICIAN / MIDWIFE:_____

COMPLICATIONS DURING PREGNANCY?_____Y_____N, LIST:_____

COMPLICATIONS DURING DELIVERY? _____Y_____N, LIST:_____

ULTRASOUNDS DURING PREGNANCY? _____Y_____N, NUMBER_____

MEDICATIONS DURING PREGNANCY / DELIVERY?_____Y_____N, LIST:_____

LOCATION OF BIRTH: _____HOSPITAL_____BIRTHING CENTER_____HOME

BIRTH INTERVENTION: _____FORCEPTS_____VACUUM EXTRACTION _____CESSARIAN SECTION, EMERGENCY OR PLANNED?

APGAR SCORES:_____,_____ CIGARETTE / ALCOHOL USE DURING PREGNANCY: Y / N

GENETIC DISORDERS OR DISABILITIES:_____Y_____N, LIST:_____

BIRTH WEIGHT:_____ BIRTH LENGTH:_____

FEEDING HISTORY:

BREASTFED: _____Y_____N, HOW LONG:_____

FORMULA: _____Y_____N, HOW LONG:_____, TYPE:_____

INTRODUCED: SOLIDS AT_____MONTHS, COWS MILK AT_____MONTHS

FOOD / JUICE ALLERGIES OR INTOLERANCES:_____N_____Y, LIST:_____

DEVELOPMENT HISTORY:

AT WHAT AGE WAS YOUR CHILD ABLE TO:

_____RESPOND TO SOUND
_____RESPOND TO VISUAL STIMULI
_____HOLD HEAD UP
_____SIT UP
_____CROSS CRAWL
_____STAND ALONE
_____WALK ALONE

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APROXIMATELY 50% OF CHILDREN FALL FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (i.e. A BED, CHANGING TABLE, DOWN STAIRS, ETC.). WAS THIS THE CASE WITH YOUR CHILD?_____Y_____N

IS / HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS (i.e. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.)?_____Y_____N, LIST:_____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT?_____Y_____N, LIST:_____

HAS YOUR CHILD BEEN SEEN ON AN EMERGENCY BASIS?_____Y_____N, LIST:_____

OTHER TRAUMAS NOT DESCRIBED ABOVE?_____Y_____N, LIST:_____

PRIOR SURGERY:_____Y_____N, LIST:_____

CHILDHOOD DISEASES:

CHICKEN POX Y / N, AGE_____
RUBELLA Y / N, AGE_____
RUBEOLA Y / N, AGE_____
MUMPS Y / N, AGE:_____
WHOOPING COUGH Y / N, AGE:_____
OTHER Y / N, AGE:_____

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

SIGNED:_____WITNESSED:_____DATE:____/____/____

Name: _____Date: _____ #_____

Acknowledgements:

- ☐ I grant permission to be called, texted, and or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
  By submitting this form and signing up for text appointment reminders, you consent to receive messages from Care Chiropractic at the number provided, including messages sent by autodialer. Consent is not a condition of treatment. Msg & data rates may apply. Msg frequency varies. Unsubscribe at any time by replying STOP. Reply HELP for help.
- ☐ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
  Date of last menstrual period (MM/DD/YY): _____
- ☐ I understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient:_____
Signature: _____ Date: _____

Parent or Guardian: _____
Signature: _____ Date:_____

Witness Name: _____
Signature: _____ Date:_____