ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES
Pediatric Application for Care

Dear New Patient,

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. 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.

Patient Name _____ Birth Date: _____ Age_____ Date_____

Address _____ Zip: _____

Best Phone _____ Guardian's Home Phone _____ Email Address _____

Sex _____ Weight _____ Height _____ Referred By _____

Names of Parents/Guardians _____ Number of Siblings _____

Reason for Contacting Us _____

Other doctors seen for this condition (Names, dates, and types of treatments) _____

_____

Other health problems _____

Check any of the following conditions and the age at which it happened:

Ear Infections ____	Digestive Problems____	Car Accident _____	Headaches _____
Asthma/Allergies____	Bed Wetting _____	Chronic Colds _____	Growing/Back Pains ____
Colic/Reflux _____	Seizures _____	Recurring Fever ____	Difficulty breastfeeding___
Scoliosis_____	ADHD ____	Temper Tantrums ____	Head tilted/turned to side__

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 has received there? ____ Explain _____

Number of doses of <u>antibiotics</u> your child has taken: In past 6 months ____ During his/her lifetime ___

List of Antibiotics taken _____

Vaccination History _____

<u>Prenatal History</u>

Name of Obstetrician/Midwife _____

Complications During Pregnancy? □ Yes □ No If yes, list _____

During Pregnancy:

Ultrasounds? □ Yes □ No If yes, how many? _____ Medications _____

Cigarette/Alcohol Use □ Yes □ No Falls/Injuries □ Yes □ No Physical/Mental Abuse □ Yes □ No

Location of Birth □ Home □ Birthing Center □ Hospital Name _____

Birth Intervention □ Forceps □ Vacuum Extractor □ C-Section □ Emergency □ Planned

Breech/Transverse _____ Labor Induced □ Yes □ No Length of Delivery _____

Complications During Delivery □ Yes □ No If yes, list _____

Genetic Disorders/Disabilities _____ Birth Weight ____ Length ____ APGAR Score ____

Feeding History

Breast Fed □ Yes □ No How Long _____ Formula Fed □ Yes □ No How Long _____ Type _____

Age Introduced to Solids ____ Age Introduced to Cow's Milk ____ Food/Juice Allergies _____

Developmental History

During the following times 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 ages was your child able to:

Respond to Sound _____ Walk Alone _____ Sit Up _____
Hold Head Up____ Respond to Visual Stimuli ___
Cross Crawl _____ Stand Alone _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, a changing table, down stairs, etc). Was this the case with your child? □ Yes □ No Explain _____

Has your child been involved in any high impact or contact sports (i.e. Soccer, Football, Gymnastics, Cheerleading, Baseball, Martial Arts, etc.) □ Yes □ No List _____

Has your child been involved in a car accident (even a fender bender)? □ Yes □ No If yes, was your child strapped? □ Yes □ No

Has your child ever been taken to the emergency room? □ Yes □ No Explain _____

Other traumas not described above _____

Prior Surgery □ Yes □ No Type and Age _____

Childhood Diseases:
Check the box if your child has had one of the listed and fill in the age when they had it.

□ Chicken Pox _____ □ Mumps ____ □ Rubella _____
□ Whooping Cough ____ □ Rubeola _____ □ Other _____

WE ARE HERE TO SERVE YOU AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

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. Any risks regarding chiropractic care will be explained to me upon my request.

Signed _____ Date _____

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

(904)247-3933 or (904)479-0363

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both 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 subluxation. 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 metal 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 chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those 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 innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I hereby authorize payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance to the doctors. I hereby authorize the attending doctor to release any information concerning my examination or treatment. If an outstanding balance is not paid within 30 days, I will be responsible for all costs incurred for collections, including reasonable attorney fees.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Name_____Signed_____

Date_____

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

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Please initial **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

____ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

Please initial **TREATMENT AUTHORIZATION**

____ I understand that if I am accepted as a patient by Alterman & Johnson Family Chiropractors, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic care will be explained to me upon my request.

____ I hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. PLEASE LEAVE THIS BLANK IF YOU ARE PREGNANT

____ I consent to receiving voicemail/text messages from Alterman & Johnson Family Chiropractors/Blooming Bellies related to my protected healthcare information at (phone number) _____. I understand I may be charged for such calls by my wireless carrier.

_____

Print Name Date

_____

Signature (Patient or Parent/Guarding)

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize of Alterman & Johnson Family Chiropractors to administer treatment as they deem necessary to my child (name)_____.

_____

Parent/Guardian Signature Date