Thompson Chiropractic

# Supplemental Infant/Child Assessment Form

Date _____

Patient Name: _____

Place of birth: ❍ Home ❍ Birthing Center ❍ Hospital ❍ Other, please list: _____

Type of Birth: ❍ C-section ❍ Vaginal

Was ultrasound used during pregnancy? ❍ Yes ❍ No If yes, how many times: _____

Was labor induced? ❍ Yes ❍ No If yes, why: _____

_____

Was Anesthesia used? ❍ Yes ❍ No Type(s) of Anesthesia use: _____

_____

Was there any notable Doctor assisted birth trauma? ❍ Twisting or Pulling ❍ Vacuum Extraction ❍ Forceps ❍ Other: ___

_____

Were there any special medical procedures or tests performed? ❍ Yes ❍ No If yes, please list: _____

_____

Was the child breast fed? ❍ Yes ❍ No If yes, to what age: _____

According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life.

Can you recall ANY jolts, falls, or traumas to this child? ❍ Yes ❍ No If yes, please describe: _____

_____

Has this child experienced any fractures or dislocations? ❍ Yes ❍ No Please describe:_____

Other than the time spent sitting in a classroom, does your child spend prolonged time sitting? ❍ Yes ❍ No

Which activities does this child participate in? ❍ Soccer ❍ Football ❍ Gymnastics ❍ Karate ❍ Hockey ❍ Basketball ❍ Video Games ❍ Dance ❍ Wrestling ❍ Baseball ❍ Softball ❍ Cheerleading ❍ Other: _____

How would you rate your child's overall diet? ❍ Poor ❍ Somewhat Healthy ❍ Healthy

Please mark any of the following conditions your child has experienced: ❍ Colic ❍ Irregular Sleeping Patterns ❍ Nightmares ❍ Seizures ❍ Tantrums ❍ Ear Infections ❍ Allergies ❍ Asthma ❍ Headaches ❍ Poor Digestion ❍ Repeated Infections or Colds ❍ Bed Wetting ❍ Learning Disorders ❍ Emotional Disorders ❍ ADD or ADHD ❍ Other: _____

_____

Please list all medications your child has been treated with since birth: _____

_____

_____

Were you informed of any adverse reactions to any of the above listed medications? ❍ Yes ❍ No

## Authorization

I hereby authorize the Doctors and Staff at Thompson Chiropractic Clinic, P.A. to examine and treat my ❍ Son ❍ Daughter.
Having carefully read the attached informed concent, I hereby give my informed concent to have chiropractic treatment administered.

Parent/Legal Guardian Signature: _____ Date: _____

## Personal Information

Address: _____

City / State / Zip: _____

Home Phone: (  ) _____ Work Phone: (  ) _____

Mobile Phone: (  ) _____ Email: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: ❍ M ❍ F

Occupation: _____ Employer's Name: _____

Work Address: _____

City / State / Zip: _____

Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name: _____ # of Children: _____

Children's information: _____

How were you referred to Thompson Chiropractic Clinic, P.A.? _____

_____

## Authorization & Assignment

I authorize Thompson Chiropractic Clinic, P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Thompson Chiropractic Clinic, P.A. authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date _____ Patient's Signature _____

## Informed Consent

I hereby authorize doctors and staff at Thompson Chiropractic Clinic, P.A. to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Thompson Chiropractic Clinic, P.A. responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Soreness** - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

**Soft Tissue Injury** - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

**Rib Injury** - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

**Physical Therapy Burns** - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke** - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

**Other Problems** - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date _____ Patient's Signature _____