BOUNDLESS CHIROPRACTIC

Pediatric Practice Member Application

Name: _____ Date of Birth: _____ /_____ /_____ Age: _____ ☐ Male ☐ Female

Address: _____ City:_____ State:_____ Zip:_____

Height: _____ Weight: _____ Child's Social Security #: _____

Guardian(s) Name:_____ Relationship: _____

Guardian's Email Address: _____ Phone Number: _____

Who may we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW

Health Concern: (List according to severity)	**Rate of severity** 0 = no pain 10 = unbearable	**When did this problem start?**	**Have you had the problem before? If so, when?**	**Did the problem begin with an injury?**	**Are symptoms Constant (C) Intermittent (I)?**
First:					
Second:					
Third:					

Have you seen other doctors for these conditions? ☐ Yes ☐ No

If Yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other: _____

Who? _____ When? _____ Results? _____

Has your child experienced any bowel or bladder problems since this problem began? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever experienced this problem before? ☐ Yes ☐ No If yes, when? _____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other(s): _____ _____ _____

___ Scoliosis ___ Cancer ___ Spina Bifida ___Spinal Surgery ___ Diabetes

___ Spinal Bone Fracture ___ Arthritis ___ Seizures Other:_____

Pregnancy Information

Overall, how was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy? _____

Other pertinent information: _____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Cesarean Section

Induced? ☐ Yes ☐ No If yes, please explain: _____

Medications during delivery? _____

Other information: _____

Post Birth Information

Birth Weight: _____ Birth Length: _____

Breast Fed? ☐ Yes ☐ No If yes, how long? _____ Formula Fed? ☐ Yes ☐ No If yes, how long?_____

Solid foods introduced at _____ months Food allergies or intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months: _____ Total Lifetime: _____

Please list any medication your child currently taking, its dosage, and purpose: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

List all surgical operations and years: _____

Has your child ever been knocked unconscious? ☐ Yes ☐ No Has your child ever fractured a bone? ☐ Yes ☐ No

If yes to either of the above, please describe: _____

Has your child ever been in a car accident? ☐ Yes ☐ No If yes, did they sustain an injury? ☐ Yes ☐ No

Please explain: _____

Does your child participate in organized sports? ☐ Yes ☐ No If yes, have they ever sustained an injury? ☐ Yes ☐ No

Please explain: _____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No Pain Back pain Headaches Worst Possible Pain

0 1 2 3 4 (5) 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

_____ _____

PLEASE PRINT NAME HERE **DATE**

ACTIVITIES OF LIFE

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their life:

ACTIVITY:	EFFECT:			
Holding Head up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Tummy Time	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Nursing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting Up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Crawling	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing Alone	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking Alone	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration at School	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

PLEASE PRINT NAME HERE **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 include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occuring at a rate between one instance per one million to one per two million cervical spine (neck) 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 health care 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.
- I authorize and request payment of insurance benefits directly to Kason Belnap, D.C. 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 practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____

PRINT NAME OF GUARDIAN

_____ _____

GUARDIAN SIGNATURE **DATE**

WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: _____

I authorize Dr. Kason Belnap and any and all Boundless Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Boundless Chiropractic.

_____ _____

GUARDIAN SIGNATURE **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

GUARDIAN SIGNATURE **DATE**

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. There is no fee for a requested copy of x-rays. However, advanced notice is appreciated. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Boundless Chiropractic does 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 NAME OF GUARDIAN **CHILD'S DATE OF BIRTH**

_____ _____

GUARDIAN SIGNATURE **DATE**