ANTONIOTTI CHIROPRACTIC

1820 S. Westnedge Ave. Suite #1. Kalamazoo, MI 49008

269.344.5551 antoniottichiropractic.com

INTRODUCTION + PEDIATRIC HEALTH HISTORY
3 - 7 YEARS OLD

We are excited that you have chosen Antoniotti Chiropractic to assist in the health and wellness needs of you and your family! Let us know if there is anything we can do to make you more comfortable. Please complete this form as much as possible so that we can provide the best possible care for your family.

Child's Name: _____ Date:_____

Home Address: _____ City, State, Zip: _____

Age: _____ Date of Birth: _____ / _____ / _____ Male ☐ Female ☐ Weight: _____ Height: _____

INTRODUCTION

PARENT(S) / LEGAL GUARDIAN(S):

Parent Name: _____

Phone: _____

Employer: _____

DOB: _____

Email: _____

Name: _____

Phone: _____

Employer: _____

DOB: _____

Email: _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

Who is responsible for your bill? Self ☐ Spouse ☐ Other ☐ Insurance Company: _____ Policy #_____

Referred by: _____

Previous Chiropractic Care: ☐ Yes ☐ No Date: _____ Doctor: _____

Were X-rays taken: ☐ Yes ☐ No Date: _____

REASONS FOR SEEKING CHIROPRACTIC CARE:

At Antoniotti Chiropractic, we focus on your child's ability to be healthy. Our goals are to first address the issues that brought your child to this office and second, to offer your child the opportunity of improved health, wellness, and quality of life in the future.
Please briefly describe the main concern that you would like Antoniotti Chiropractic to address for your child:

_____

_____

Other doctors seen for **this condition**: ☐ Chiropractor ☐ Medical Doctor ☐ Other- please list _____

1. Name: _____ City: _____ Date: _____ X-rays taken: ☐ Yes ☐ No

Special tests done: ☐ Yes ☐ No Diagnosis: _____ What was done: _____

2. Name: _____ City: _____ Date: _____ X-rays taken: ☐ Yes ☐ No

Special tests done: ☐ Yes ☐ No Diagnosis: _____ What was done: _____

HEALTHCARE PRACTITIONER HISTORY

Has your child ever had chiropractic care? ☐ Yes ☐ No Name of D.C. _____

How long under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why was care stopped? _____ Are you satisfied with care received there? ☐ Yes ☐ No

Has your child consulted or does he/she regularly consult any of the following providers? (Check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath ☐ Massage Therapist ☐Psychotherapist ☐ Optometrist ☐ Dentist

Reason why: _____

Name of Pediatrician: _____ City: _____ Date of last visit: _____ Reason: _____

_____ Are you satisfied with care received there? ☐ Yes ☐ No

Patient Name: _____

Please list any/all medications your child is taking at this time and precise dosage per day in mg. Please include prescription drugs, over the counter medications, and any vitamins and supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please explain your child's current health challenge(s)

_____

_____

_____

_____

_____

Please attach additional sheet if necessary.

CHILD'S HEALTH PROFILE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM. The information below will help us to see the types of PHYSICAL, CHEMICAL, & EMOTIONAL stresses your child has been subjected to and how they may relate to his/her present spinal, nerve, and health status.

GENERAL HISTORY:

Please mark all symptoms your child has ever had, even if they do not seem related to the current problem:

☐ Ear infections ☐ Asthma ☐ ADHD ☐ Anemia ☐ Leg problems ☐ Orthopedic problem ☐ Constipation

☐ Arm problems ☐ Sinus problems ☐ Seizures ☐ Allergies ☐ Recurrent fevers ☐ Reflux ☐ Diabetes ☐ Neck problems

☐ Diarrhea ☐ Back problems ☐ Intestinal gas ☐ Chronic colds ☐ Digestive problems ☐ Colic ☐ Behavioral probelms

☐ Heart trouble ☐ Joint problems ☐ Poor appetite ☐ Trouble walking ☐ Other: _____

Please list any other **serious medical conditions** your child currently has or has ever had: _____

_____

PARENTAL HISTORY:

Name of Obstetrician/Midwife: _____

Social history while pregnant:

Did you: ☐ Exercise regularly ☐ Eat a balanced diet ☐ Obtain sufficient rest

Did you: Smoke ☐ No ☐ Yes- How many packs per day? _____ Drink alcohol: ☐ Yes ☐ No- How many drinks per day? _____

Did you: Drink caffeine ☐ No ☐ Yes- In what form (coffee, tea, etc.) _____

Please list any medications/supplements taken while pregnant: _____

_____

Were there complications during pregnancy? ☐ No ☐ Yes- please explain: _____

LABOR + DELIVERY:

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home Birth Intervention: ☐ Forceps ☐ Vacuum extraction ☐ Cesarean section

Were there complications during delivery? ☐ No ☐ Yes- please explain: _____

Birth weight: _____ Birth length (inches): _____

FEEDING HISTORY:

Breast-fed: ☐ No ☐ Yes- How long (months)? _____ Donor milk: ☐ No ☐ Yes- How long (months)? _____

Does baby prefer feeding on one side more than the other? ☐ No ☐ Yes- Which side? _____

After feeding, does baby frequently spit-up? ☐ No ☐ Yes Introduced to solids at _____ months

Food/Drink allergies, sensitivities, or intolerances: ☐ No ☐ Yes- please list: _____

_____

STRESSORS

Patient name:_____

PHYSICAL STRESS:

Has your child ever suffered from the following spinal traumas

☐ Fall in baby walker ☐ Fall from bed or couch ☐ Fall off swing ☐ Fall from highchair ☐ Fall from crib ☐ Fall down stairs

☐ Fall off slide ☐ Fall off changing table ☐ Fall off monkey bars ☐ Other: _____

Has your child ever been involved in **organized sports** (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, etc.)? ☐ No ☐ Yes

please explain: _____

Has your child ever been in a **car accident**? ☐ No ☐ Yes- please explain: _____

Has your child ever had a **bone fracture or joint dislocation**? ☐ No ☐ Yes- please explain: _____

Has your child had any **other traumas** not described above? ☐ No ☐ Yes- please explain: _____

Do you feel your child's **book bag** is too heavy for him/her? ☐ No ☐ Yes

How many hours per day does your child do each of the following?

Watch T.V. _____ Use a computer _____ Play video games _____

Does your child **sleep through the night**? ☐ Yes ☐ No- please explain: _____

On average, how many **hours of sleep** does your child get per night? _____

CHEMICAL STRESS:

Vaccination history: ☐ Up to date ☐ Alternative schedule ☐ Other : _____

Number of **doses of antibiotics** your child has taken: During the past 6 months: _____ Total during lifetime: _____

Do you have any concerns with your **child's diet**? ☐ No ☐ Yes- please explain: _____

_____

EMOTIONAL STRESS:

Does your child have **difficulty focusing on a task**? ☐ No ☐ Yes- please explain: _____

_____

Does your child get **angry easily**? ☐ No ☐ Yes- please explain: _____

_____

ADDITIONAL QUESTIONS

If there is a need for dietary changes or nutrients, would you like to be informed? ☐ Yes ☐ No

If there is a need for specific exercises, would you like to be informed? ☐ Yes ☐ No

If there is a need for support in the emotional/stress area of health, would you like to be informed? ☐ Yes ☐ No

Is there any specific health topic you would like more information on? ☐ Yes ☐ No

EXPECTATIONS

I would like my child to have the following benefits from chiropractic care: (check all that apply)

☐ Relief of a symptom or problem

☐ Relief and prevention of a symptom or problem

☐ Healthier spine and nerve system

☐ Best possible health on all levels

THANK YOU FOR CHOOSING ANTONIOTTI CHIROPRACTIC!

WE LOOK FORWARD TO HELPING YOU

Patient name:_____

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CONSENT FOR PURPOSES OF TREATMENT/ PAYMENT & HEALTHCARE OPERATIONS

I acknowledge that Antoniotti Chiropractic Offices "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Antoniotti Chiropractic Offices Notice of Privacy Practices prior to signing this document. Antoniotti Chiropractic Offices Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Antoniotti Chiropractic Offices. The Notice of Privacy Practices for Antoniotti Chiropractic Offices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Antoniotti Chiropractic Offices duties with respect to my protected health information.

Antoniotti Chiropractic Offices reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Personal Representative Date

Patient name:_____

ABOUT FINANCIAL ARRANGEMENTS + HEALTH INSURANCE

PAYMENT POLICY

We are committed to providing you with the best possible care. If you have health insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered until all insurance coverage has been verified; we accept cash, check, MasterCard, Visa, and Discover. We will be happy to help process your insurance claims for your reimbursement. A completed insurance form must accompany any such requests.

Once insurance coverage has been verified we will gladly accept your insurance assignment for that portion of your bill **estimated** to be covered. Any services provided by our office, **not covered** by your insurance company, are due following notification of denial from your insurance carrier.

INSURANCE CONTRACTS

1. *Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.*
2. *Our fees are generally considered to fall within the acceptable range by most companies. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". Most insurance companies define "U.C.R." as Usual, Customary, and Reasonable.*
3. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

We must emphasize that as health care providers, **our relationship is with you, not your insurance company.**

While the filing of insurance claims is a courtesy that we extend to our patients, all changes are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account.

If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I 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 hereby authorize the doctor to treat my condition, as he deems appropriate. I understand and agree that x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____

Signature of Patient Date

Patient name:_____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay, by check made out and mailed directly to this clinic, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient Date

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and attorney involved in this case; and hereby release this clinic of any consequences thereof.

_____ _____

Signature of Patient Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

_____ _____

Signature of Patient Date

Patient name:_____

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.
The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral sublixation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made concerning the results of the care and treatment.

Patient Name	Signature of Patient	Date