



Community Chiropractic

7651 E US Hwy 36

Avon, IN 46123

(317) 272-7988

Child Chiropractic Case History

Date: _____

Doctor: Vicki Danis, DC

Emileah Van Matre, DC

Name: _____ Cell Phone: _____ Cell Carrier: _____

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

Age: _____ Birth Date: _____ Gender (circle one): M F Home Phone: _____

Name of Parents: _____

Who can we contact in case of an emergency? _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor/Pediatrician: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____



Community Chiropractic

PATIENT NAME _____

DATE _____

Doctor: Vicki Danis, DC

Emileah Van Matre, DC

HISTORY OF PRESENT AND PAST ILLNESS:

Reason for visit: _____

Start date of symptom(s): _____

Does anything make the symptom(s) better? _____

Does anything make the symptom(s) worse? _____

Has your child ever had the same or a similar condition? Yes No If yes, when and describe: _____

Who else has been consulted for this symptom? _____

Date of last doctor visit or examination: _____

CHILDHOOD EXPERIENCE:

Please describe the childbirth experience in detail: _____

Is there any history of Major illness, surgery, trauma (such as a car accident) or broken bones? If so, describe and date: _____

HISTORY OF VACCINATION:

Up to Date

Hepatitis B Rotavirus DTaP Hib (H Influenza) PCV (Pneumococcus) IPV (Polio) Flu

Tetanus Varicella Zoster Hep A MMR HPV Meningitis

MEDICATION:

What medications or drugs is your child taking? _____

Does your child have any allergies to any medications? Yes No

If yes, describe: _____

Does your child have any allergies of any kind? Yes No

If yes, describe: _____

Does your child have any Congenital Condition? Yes No If YES, Describe _____



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PATIENT NAME _____

DATE _____

Doctor: Vicki Danis, DC

Emileah Van Matre, DC

PREVIOUS CHIROPRACTIC CARE:

Has your child received chiropractic care previously? _____

If so, where? _____ Name of Doctor: _____

Describe your/their experience: _____

FAMILY HISTORY

Please indicate below if any of the following are in the child's family history, going back within the last two generations.

Cancer What kind? _____

Stroke

High Blood Pressure

Diabetes

Scoliosis

Epilepsy

Migraines

Other Describe: _____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

NAME OF PATIENT: _____

DATE _____

CONSENT TO TREATMENT OF MINOR CHILD

CONSENT TO TREATMENT OF ADULT WITH MEDICAL POWER OF ATTORNEY

I hereby authorize Dr. Vicki Danis and/or Dr. Emileah Van Matre along with whomever she may designate as her assistants to administer treatment as she so deems necessary to

_____.

(Name of Patient)

Date _____

PRINTED NAME OF PERSON AUTHORIZING TREATMENT:

Signature _____

RELATIONSHIP TO PATIENT: _____

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? _____ (Please provide our office with a copy of the medical Power of Attorney).

Witnessed: _____