Community Chiropractic
7651 E US Hwy 36
Avon, IN 46123
(317) 272-7988

Child Chiropractic Case History

Date:_____ **Doctor:** ⬭ **Vicki Crum, 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 Crum, 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 _____

Community Chiropractic

PATIENT NAME _____

DATE _____ Doctor: ⬭ Vicki Crum, 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 Crum and/or 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: _____