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

Child Chiropractic Case History

Date:__________________ **Doctor:** ⬭ **Vicki Crum, DC**

Full Legal Name:____ Cell Phone: ________________________________

Address:____City:___________________ State:______ Zip:___________

Age:_______ Birth Date:___________ Gender (circle one): M F Other 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

Doctor: Vicki Crum, DC

PATIENT NAME ___________________________________
DATE ___________________

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

Doctor: Vicki Crum, DC

PATIENT NAME ____

DATE ____________________

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: ____