

Modern Health Chiropractic

Child Interview

Thank you for trusting us with your child's health!

Child's name _____ Date _____

Child's Birth Date _____

Parent(s) name _____

Address _____ City _____ State ____ Zip _____

Parent/guardian contact information :

Home Phone _____ Work Phone _____ Cell _____

(Please circle the phone number that is best to reach you at during our office hours.)

How did you discover our office? _____

Reason for consulting our office today: _____

What are your expectations for your child's care in this office? _____

Please list any concerns for your child in order of importance:

1. _____ 2. _____ 3. _____

Have you seen any other professional for these concerns? Y N

If yes, describe the treatment and any results:

Please check each of the following that has ever applied to your child

Please check each of the following that has ever applied to your Health

- | | | |
|--|---|--|
| <input type="checkbox"/> Frequent sickness | <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> School difficulties |
| <input type="checkbox"/> Ear infections (aching) | <input type="checkbox"/> Poor balance or coordination | <input type="checkbox"/> Stress or Anxiety |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Social fears/ problems |
| <input type="checkbox"/> Often unhappy/depressed problems | <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Scoliosis/ Spinal |
| <input type="checkbox"/> X-rays or MRI | <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Car accidents |
| <input type="checkbox"/> Spinal or head injury | <input type="checkbox"/> Falls | <input type="checkbox"/> Neurological conditions |
| <input type="checkbox"/> Birth Trauma (forceps, vacuum, c-section) | | <input type="checkbox"/> Developmentally slow |
| <input type="checkbox"/> Sleeping issues | <input type="checkbox"/> Lack of muscle coordination | <input type="checkbox"/> Muscle weakness |

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your child.

Has your child ever been to a Chiropractor before? Y N When _____

Why did he/she go? _____

What were the results? _____

Why did you stop care? _____

Does your child have any conditions that may alter the way in which their care is delivered?

Describe how your child's quality of:

Sleep _____

Diet _____

Exercise _____

Does your child take any nutritional supplements, vitamins, or medications? (Please explain)

Does your child participate in any sports, lessons, talents, or hobbies? (Please explain)

What are your most important goals for your child's health and life?

Is there anything else that we need to know about your child that was not addressed on this form?

Payment Policy

Payment is due at the time of, or previous to, services being rendered. All fees will be explained before any professional services are rendered. If you have insurance you may be able to be reimbursed for part of your expenses at our office.

We ask that you kindly give 24 hours notice to change an appointment. Office policy is that missed appointments that are not cancelled or rescheduled with 24 hours notice are subject to a \$20 fee for each 10 minute time period scheduled.

Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather we care for the spine for the sole purpose of removing interference with and tension from the Nervous System. We also employ extremity work to improve muscle and joint stability and function. Every person is better with improved neural and musculo-skeletal function and this alone justifies our care. Research studies report improved health and wellness that is consistent with the care given. However, just what specific benefits your child will receive, no one can predict.

By my signature I give my consent to Modern Health Chiropractic LLC to use my client information and for a Doctor of Chiropractic to examine my child's spine and extremities. If I choose for my child to receive Chiropractic care, my payment for such services, and my bringing my child to each visit, in addition to my signature here; will serve as acknowledgment of my permission for a doctor of chiropractic to deliver such care to my child.

Privacy Notice

Your Child's health information is private and protected by law. This health information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations in this office. You have a right to review the office file. You may restrict all or part of the health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

I have had a chance to ask questions about the privacy policy and I give my permission to Modern Health Chiropractic LLC to disclose my protected health information in accordance with such policies.

Parent/Guardian Signature

Date

Witness Signature

Date