PATIENT APPLICATION FORM:
CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

_____

PATIENT NAME

_____

DATE COMPLETED

Patient Information

Name:_____ (Age)_____Gender: M F

Home Address:_____ Birth Date:_____ /_____/_____

City, State, Zip:_____Cell Phone: ( )_____

Name of Mother/Guardian:_____ Home Phone: ( )_____

BirthDate:_____/_____/_____(Age)_____ Marital Status: S M D W Work Phone: ( )_____

Home Address (if different):_____ Cell Phone: ( )_____

City, State, Zip:_____Email:_____

Employer Name:_____Occupation:_____

Name of Father/Guardian:_____ Home Phone: ( )_____

BirthDate:_____/_____/_____ (Age)_____Marital Status: S M D W Work Phone: ( )_____

Home Address (if different):_____ Cell Phone: ( )_____

City, State, Zip:_____Email:_____

Employer Name:_____Occupation:_____

How were you referred to this office?_____

Purpose For This Visit

Reason for this visit:_____

Is this related to an accident or specific injury (other than auto or work-related)*? Yes No If yes, when:_____ /_____/_____

If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms:_____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin?_____/_____/_____ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes No Do they interfere with: School Sleep Hobbies/Play Daily Routine

Explain:_____

_____

What activities aggravate these symptoms?_____

Is there anything that relieves your symptoms? Yes No If yes, explain:_____

Has your child experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain:_____

_____

Has your child been treated for this? Yes No When was the last treatment?_____/_____/_____

Name of treating practitioner/facility?_____

What treatment(s) was performed?_____

How did your child respond?_____

Health Conditions *continued*...

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Colic
____ Sore throats
____ Auto-Immune Diseases
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Ear Infections
____ Learning disabilities
____ Other (please explain)
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking
____ Flu/Stomach disorders
____ Hyperactivity/ADD

Explanation(s): _____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Shingles
____ Upper Back Pain
____ Recurrent Lung Infections/Bronchitis/Pneumonia
____ Heart Murmurs
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Asthma/Wheezing
____ Tachycardia (fast heart beat)
____ Other (please explain)

Explanation(s): _____

_____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Liver problems
____ Tired/Irritable after eating or when not having eaten for a while
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Spleen problems
____ Diabetes
____ Hypoglycemia
____ Diabetes
____ Other (please explain)

Explanation(s): _____

_____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Involved in a car accident
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s):_____

_____

Birth Experience How long was labor? Describe any complications:_____

_____

_____

_____

Type of delivery: Vaginal C-Section Vacuum Extraction Forceps Assistance

VACCINATION HISTORY

Has your child received any vaccinations? Yes No

Please check any of the following responses your child experienced as a result of a vaccination.

____ Swelling, redness, heat/hardness of site
____ Body rash or hives
____ High fever (over 103 degrees)
____ High-pitched screaming
____ Extreme sleepiness or unresponsiveness
____ Body twitching or paralysis
____ Breathing problems (asthma, etc.)
____ Excessive bleeding or anemia
____ Head banging
____ Excessive diarrhea or chronic constipation
____ Loss of memory/foggy state
____ Muscle weakness
____ Chronic ear or respiratory Infections
____ Vision or hearing disturbances
____ Joint pain
____ Crossing of eyes
____ Seizures
____ Other (please explain)

Explanation(s):_____

_____

_____

_____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a health and wellness center our one main goal is to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedure.

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations, that I will not receive the full benefit from these programs;and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Name Printed_____

Parent/Guardian's Signature_____Date____/____/_____

Relationship to Patient_____

INSURANCE INFORMATION

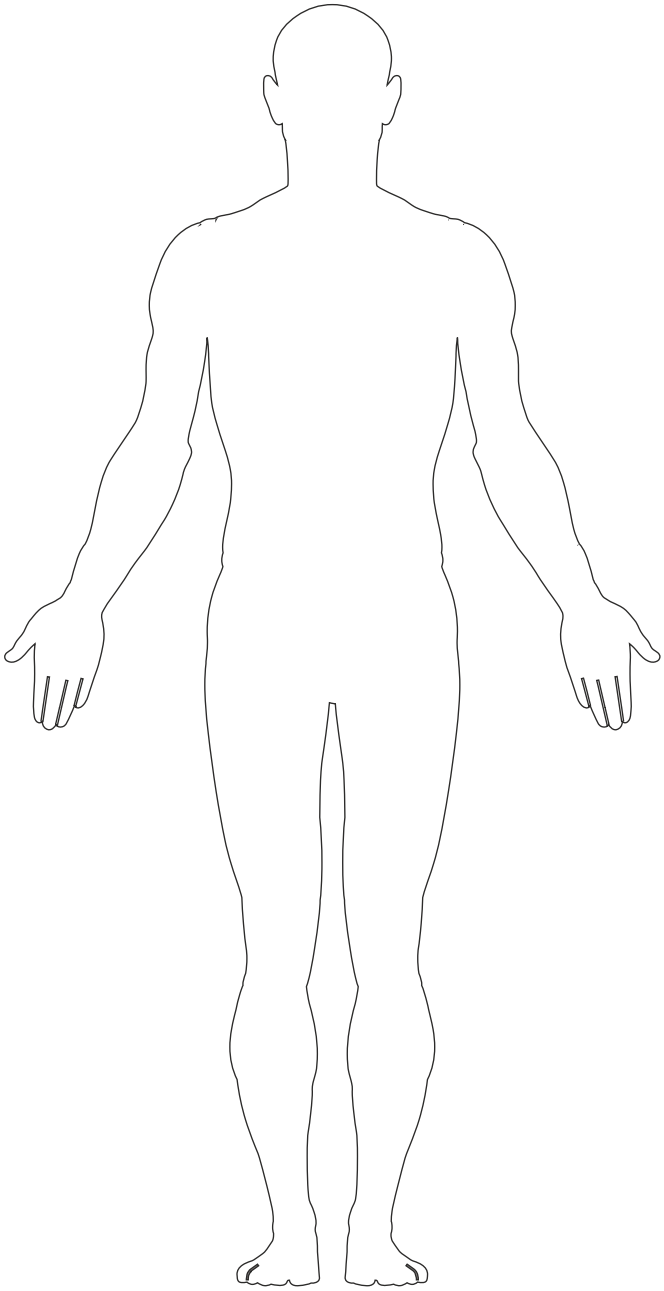
I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date _____/_____/_____

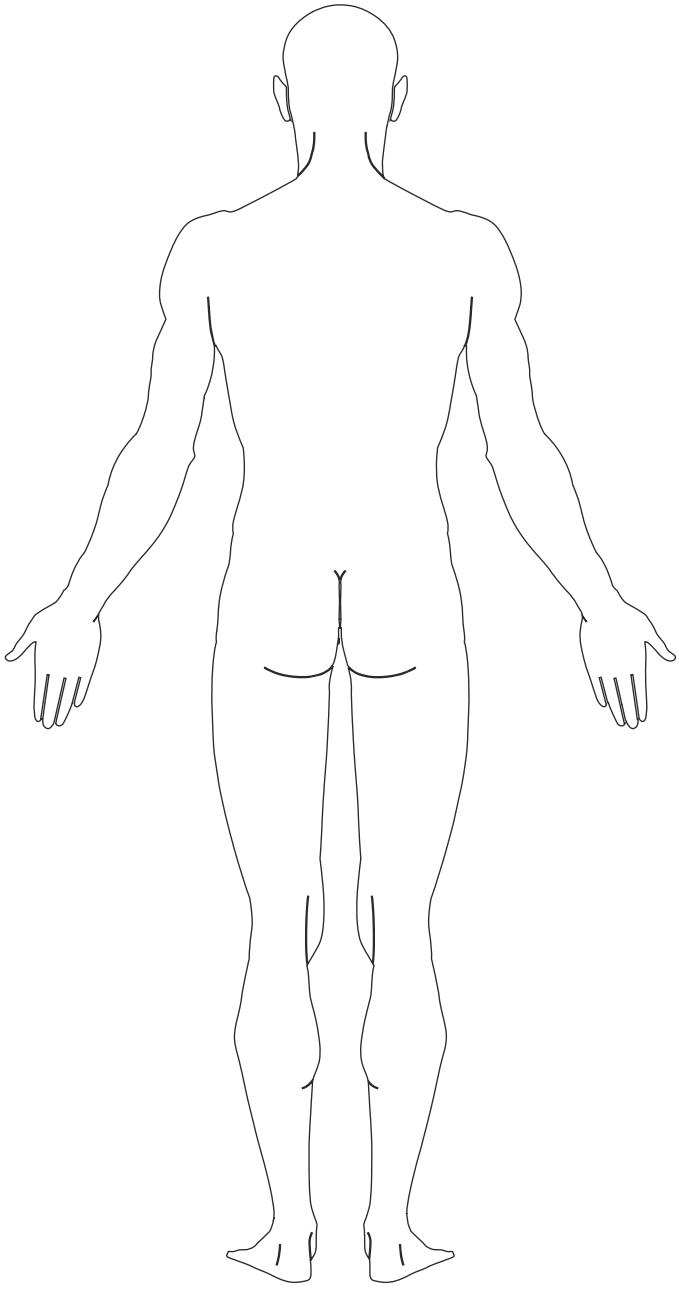
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS F	T = TINGLING
P = PINS & NEEDLES	= STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for Other on any part, please explain below:

Acknowledgement of Receipt of Notice of Privacy Practices

1422 N . College Ave.
Fayetteville, AR 72703
(479) 442-2755

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent.
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.
- ❑ Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.
By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient's Printed Name:_____

Signature:_____Date:_____/_____/_____

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: ___

Consent to x-ray

I hereby grant Generations Health and Wellness Center permission to perform an x-ray evaluation of my child if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Guardian Signature:_____Date:____/____/____

Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:____/____/____

Guardian Signature:_____Date:____/____/____

Health Conditions *continued*...

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in your legs/feet
____ Frequent/difficulty urinating
____ Menstrual irregularities/cramping (females)
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Other (please explain)
____ Low back pain
____ Coldness in legs/feet
____ Constipation/Diarrhea

Explanation(s): _____

_____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

Please list any medications (include name, dose, for what condition, and how long your child has been taking it):_____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).***:

____ ADD
____ Arthritis
____ Broken bones/fractures
____ Circulatory problems
____ Ear Infections
____ Fetal drug exposure
____ Heart disease
____ High blood pressure
____ Kidney Disease
____ Measles
____ Neurological problems
____ Pneumonia/Bronchitis
____ Scoliosis
____ Spinal Bifida
____ Tuberculosis
____ Allergies/Hay fever*
____ Asthma
____ Cancer
____ Crohn's/Colitis
____ Eczema
____ Food allergies*
____ Heart murmur
____ HIV
____ Liver disease
____ Metal implants
____ Osteoporosis
____ Polio
____ Seizure disorder
____ Stroke
____ Varicose veins
____ Anemia
____ Bed wetting
____ Cerebral Palsy
____ Depression
____ Eczema/Psoriasis
____ Gall bladder
____ Hepatitis
____ Infectious disease
____ Lumbago
____ Migraine headaches
____ Paralysis
____ Rash
____ Sickle cell anemia
____ Thyroid problems
____ Whooping cough
____ Appendectomy
____ Blood sugar problems
____ Chicken pox/shingles
____ Diabetes
____ Epilepsy/seizures
____ Headaches
____ Hernia
____ Influenza
____ Lung disease
____ Mumps
____ Pleurisy
____ Rheumatic fever
____ Small Pox
____ Tonsillectomy
____ Other*

Explanation of (*) item(s): _____

_____