generations
Health and Wellness Center

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patent in our clinic.

We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, know we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know that if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

____

PATIENT NAME

____

DATE COMPLETED

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ____________________

Address ____________________

City ____________________ State ________

Home Phone ____________________

Cell Phone ____________________

Email ____________________

Sex ❑ M ❑ F Age ______ Birthday ____________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________________

Contact Number ____________________

Mother's Name ____________________

Mother's Occupation ____________________

Mother's Phone ____________________

Mother's Email ____________________

Father's Name ____________________

Father's Occupation ____________________

Father's Phone ____________________

Father's Email ____________________

Who may we thank for referring you?

____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: ____________________

If your child is already experiencing a symptom, please describe it:

____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: ____________________

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting

❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) ____________

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech

❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? ____________________

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other ____________

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: ____________ Quality of sleep: ____________

At what age did the child:

Respond to sound: ____________ Crawl: ____________ Hold head up: ____________

Stand: ____________ Sit unsupported: ____________ Walk unsupported: ____________

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

____

____

MEDICATIONS (list)

____

____

SURGERIES (list)

____

____

FAMILY HISTORY (list)

____

____

SIBLINGS

How many children do you have? ____________

Children's' Ages: ____________

Childrens' health concerns: ____________

____

Number of pregnancies: ____________

Are you currently pregnant? ❑ No ❑ Yes, I'm due: ____________

Health concerns regarding this pregnancy? ____________

____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: ____________ Witnessed: ____________ Date: ____________

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 its 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, 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.

Signature____ **Date** ______/_______/________

Name Printed____

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** ______/_______/________

NOTICE OF PRIVACY PRACTICE

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.

HEALTH CARE INFORMATION AUTHORIZATION & APPOINTMENT REMINDERS

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.

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 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.

Signature____ **Date** ______/_______/_______

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am 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 ______/_______/_______

Signature____ **Date** ______/_______/_______