



## DEMOGRAPHICS

For office use:

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Head/Chest Circ: \_\_\_\_\_

BPM: \_\_\_\_\_

BP: \_\_\_\_\_

Patient name \_\_\_\_\_ SSN \_\_\_\_\_  
Last First MI  
Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_  
Legal Guardian (if different) \_\_\_\_\_  
I would prefer to be called \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ M  F   
When was the last time you saw a Chiropractor? \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Who may we thank for your referral? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

### Authorization for Examination of a Minor

I, \_\_\_\_\_, hereby authorize and consent to the chiropractic examination of my infant, child or adolescent.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## CHIROPRACTIC CARE

Has your child ever seen a chiropractor? Yes  No  Whom \_\_\_\_\_ Date \_\_\_\_\_  
Is your child on any medications? Yes  No  Please list all \_\_\_\_\_  
Has your child had any surgeries? Yes  No  Please list all \_\_\_\_\_  
Please describe any hospital visits for your child \_\_\_\_\_

## QUESTIONS FOR THE CHILD'S MOTHER

Did you carry your child full term? Yes  No  Weeks Gestation: \_\_\_\_\_  
Describe any complications with pregnancy/delivery and when they occurred \_\_\_\_\_  
Hours of Labor: \_\_\_\_\_ Hours of Pushing: \_\_\_\_\_ Birth Weight/Length: \_\_\_\_\_ APGAR Score: \_\_\_\_\_  
Were forceps used? Yes  No  Was vacuum extraction used? Yes  No   
Epidural? Yes  No  Did you breastfeed? Yes  No   
C-Section? Yes  No  Vaccinations? On Schedule  Delayed  Not Vaccinated   
Did you consume alcohol during your pregnancy? Yes  No   
Did you smoke during your pregnancy? Yes  No   
Did you take any medications during your pregnancy? Yes  No   
Additional information regarding pregnancy and birth: \_\_\_\_\_

**AS A BABY/TODDLER (BIRTH TO 4 YEARS), DID YOUR CHILD EXPERIENCE ANY OF THE FOLLOWING?**

- |   |   |
|---|---|
| <input type="checkbox"/> Fall from a changing table     | <input type="checkbox"/> Frequent crying            |
| <input type="checkbox"/> Fall out of crib               | <input type="checkbox"/> Frequent fever             |
| <input type="checkbox"/> Involved in an auto accident   | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Fall from playground equipment | <input type="checkbox"/> Constipation               |
| <input type="checkbox"/> Frequent ear infections        | <input type="checkbox"/> Sleeping problems          |
| <input type="checkbox"/> Tonsillitis                    | <input type="checkbox"/> Frequent colds             |
| <input type="checkbox"/> Colic                          | <input type="checkbox"/> Difficulty gaining weight  |
| <input type="checkbox"/> Other _____                    |   |

Please explain any boxes checked above \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**AS A CHILD (5-12 YEARS), DID YOUR CHILD EXPERIENCE ANY OF THE FOLLOWING?**

- |   |  |
|---|--|
| <input type="checkbox"/> Fall from tree                 | <input type="checkbox"/> Bed wetting   |
| <input type="checkbox"/> Fall from playground equipment | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Involved in an auto accident   | <input type="checkbox"/> Autism        |
| <input type="checkbox"/> Sports injury/accident         | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Stomach pains                  | <input type="checkbox"/> Allergies     |
| <input type="checkbox"/> Scoliosis                      | <input type="checkbox"/> Leg/Knee pain |
| <input type="checkbox"/> Other _____                    |  |

Please explain any boxes checked above \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**AS A CHILD OR AN ADOLESCENT, HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Growing pains   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Arm/wrist pain         | <input type="checkbox"/> Neck/back pain  |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Shoulder pain   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Stomach problems       | <input type="checkbox"/> Knee pain       |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Weight gain/loss       | <input type="checkbox"/> Other _____     |

Please explain any boxes checked above \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Family Hx : (for office use only)*

# CONCERNS

What is your child's major complaint or concern? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Are your symptoms: getting worse?  getting better?  staying the same?

What treatment have you already received for your condition?

Medications  Physical Therapy  Chiropractic  None  Other: \_\_\_\_\_

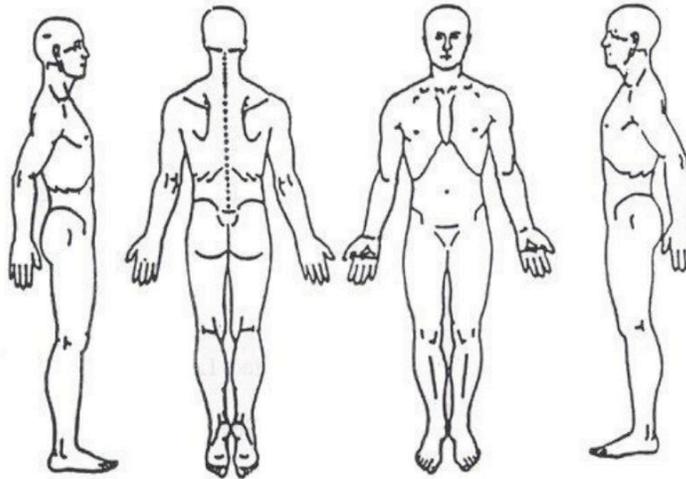
Rate the Severity of your pain on a scale from 1 (least pain) to 10 (most pain): \_\_\_\_\_/10

Type of pain:

Sharp  Dull  Throbbing  Aching  Shooting

Burning  Numbness  Tingling  Stiffness  Other

Place appropriate highlighted letters to mark the areas of discomfort



How often does this pain occur? Constant (+75%)  Frequent (50-75%)  Occasional (25-50%)  Intermittent (<25%)

Does it interfere with: Play  Sleep  Daily Routine  School

Activities or movements that are painful: Sitting  Standing  Walking  Bending  Lying Down

Other comments or concerns regarding this condition: \_\_\_\_\_

## INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below that he/she is/are a licensed chiropractor, and though rare, injury resulting from manipulation may include sprain/strain, disc herniation, stroke, death and other injuries or complications.

I agree to hold Dr. Dillon Martinek, any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatsoever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding on and insure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with the treating Doctor of Chiropractic, that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Financial and Insurance Disclaimer**

**Financial Policy**

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, and/or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. In order to make this convenient, we accept most major credit cards, cash and personal checks. If, on occasion, it is not possible to pay in full, we are willing to establish a payment schedule with you. However, the balance may not exceed \$250.00 and the full balance must be paid within 30 days. Personal balances over 30 days old may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility. A \$20.00 fee will be applied to appointments not canceled within 12 hours of the scheduled appointment time. Appointments Monday must be canceled Friday before closing.

**Insurance Policy**

Our office works with insurance companies to accept your coverage. Our staff will call the insurance company to verify your coverage and will explain to you the information they obtain. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted us. NOTE: Verification is not a guarantee of benefits. We assume no responsibility for the information we receive from your insurance company, concerning how much or what your insurance company will pay for. The final financial responsibility is yours. Should you have questions at any time, do not hesitate to contact the staff or office manager.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dr. Dillon Martinek will submit services rendered for my care for payment under the contract I have with my health and/or accident carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered to me and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any unpaid fee for professional services rendered to me will be immediately due and payable.*

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information**

The undersigned does hereby acknowledge that he or she has received a copy of this office’s Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office’s HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

CMS requires providers to report both race and ethnicity:

**Race (Circle One):** American Indian or Alaska Native/ Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer **Preferred Language:** Eng Spanish Other