STEWART CHIROPRACTIC CENTER PEDIATRIC HEALTH PROFILE

Name__________________________________ Today's Date____/____/____ Age_____ Male/Female

Address_____________________________________City____________________State_____Zip__________

Primary Contact #: ___________________ Home ( ) Cell ( ) Work ( ) Date of Birth_____/_____/______

Email __________________________________ Cell Carrier: __________________

Mother's Name (or Guardian) ___________________ Father's Name (or Guardian) _____________________

# of Siblings ______ Names, Ages, & Gender ____

Who may we thank for referring you? ____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. ______________	______________	____________	______________	______________	__________
2. ______________	______________	____________	______________	______________	__________
3. ______________	______________	____________	______________	______________	__________
4. ______________	______________	____________	______________	______________	__________
5. ______________	______________	____________	______________	______________	__________

HOW ARE THESE CONCERNS AFFECTING YOUR CHILD'S HOBBIES AND/OR DAILY LIVING? ________________

____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO WHO AND WHEN?

CHIROPRACTOR? _______________ MEDICAL DOCTOR?___________________OTHER_________________

CHECK ALL CURRENT PROBLEMS YOUR CHILD HAS

DIZZINESS	*ALLERGIES*	*IRRITABLE BOWEL*	*GROWING PAINS*	*ANXIETY/NERVOUSNESS*
NECK PAIN	*THROAT ISSUES*	*MID BACK PAIN*	*DIFFICULTY SLEEPING*	*SEIZURES*
VERTIGO	*NUMBNESS IN ARMS*	*BEDWETTING*	*CHRONIC FATIGUE*	*AUTISM*
EAR INFECTIONS	*NUMBNESS IN HANDS*	*SCIATICA*	*CHRONIC COLDS/FLU*	*TROUBLE NURSING*
NAUSEA	*ASTHMA*	*NUMBNESS IN LEGS*	*STREP THROAT*	
TMJ ISSUES	*HEART DISORDERS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*OTHER*___________
HEADACHES	*GASTRIC REFLUX*	*LOW BACK PAIN*	*ARM PAIN*	_______________
MIGRAINES	*DIARRHEA*	*HIP PAIN*	*ADD/ADHD*	_______________
SHOULDER PAIN	*CONSTIPATION*	*LEG PAINS*	*BEHAVIOR PROBLEMS*	_______________
CHRONIC SINUS	*COLIC*	*KNEE PAIN*	*TORTICOLLIS*	_______________

LIST ALL SURGERIES AND YEARS (INCLUDING *SPINAL SURGERIES*) ____________________________________

____

LIST ALL Over the Counter & PRESCRIPTION *MEDICATIONS* TAKEN: ______________________________

____

HAS YOUR CHILD EVER BEEN IN AN AUTO ACCIDENT? IF SO, WHEN?_________________________________

HAS YOUR CHILD HAD CHIROPRACTIC CARE BEFORE? NO / YES DR. & DATE:________________________

HAS YOUR CHILD EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE____

OTHER TRAUMA:____

<u>CIRCLE</u> ANY CONDITION YOUR CHILD HAS NOW/HAS HAD:

Stroke Cancer Heart Disease Spinal Surgery Spinal Bone Fracture Scoliosis

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<u>CIRCLE</u> DETAILS REGARDING YOUR CHILD'S BIRTH:

LOCATION: BORN AT HOME / BIRTHING CENTER / HOSPITAL

INTERVENTION: NONE / FORCEPS / VACUUM EXTRACTION / CAESAREAN SECTION

LIST ANY COMPLICATIONS: ____

WRITTEN CONSENT FOR A CHILD

Practice member name who is a minor/child ___________________________________

Name of person filling out profile and relationship _______________________________

I authorize Dr. Samuel Stewart and/or Dr. Clare Stewart and any and all Stewart Chiropractic Center staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Stewart Chiropractic Center.

<u>Please Circle</u>: I DO / DO NOT authorize my child to drive themselves or be brought by another family member or friend to receive recommended chiropractic adjustments or reassessments throughout their care.

______________________________ DATE

______________________________ GUARDIAN SIGNATURE

______________________________ WITNESS SIGNATURE

______________________________ GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

QUADRUPLE VISUAL ANALOGUE SCALE

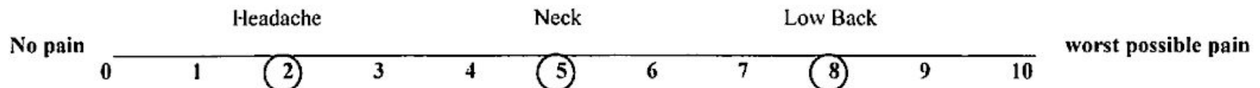
Patient Name ____________________________ Date ______________

Please read carefully:

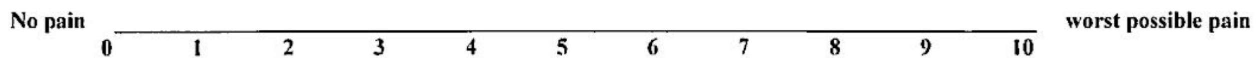
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

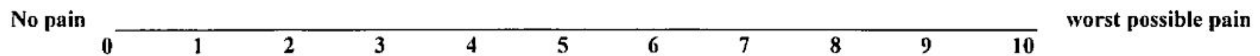
Example:



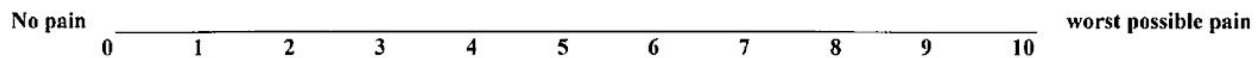
1 – What is your pain RIGHT NOW?



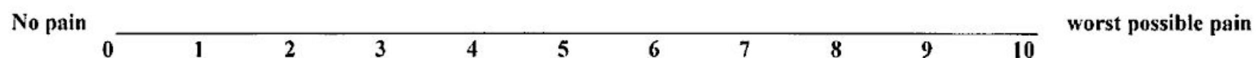
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

______________________ DATE

______________________ PLEASE PRINT YOUR NAME HERE

CONDITION	BROTHER	SISTER	MOTHER	FATHER
ARM PAIN				
ARTHRITIS				
ASTHMA				
ADD/ADHD				
ALLERGIES				
BACK TROUBLE				
BED WETTING				
CANCER				
CARPAL TUNNEL				
DECEASED				
DIABETES				
DIGESTIVE PROBLEMS				
DISC PROBLEMS				
EAR INFECTIONS				
FIBROMYALGIA				
HEADACHES				
HEARTBURN				
HIGH BLOOD PRESSURE				
HIP PAIN				
LEG PAIN				
MENSTRUAL DISORDER				
MIGRAINES				
NECK PAIN				
SCOLIOSIS				
SHOULDER PAIN				
SINUS TROUBLE				
TMJ				

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF STEWART CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

____
PRINT YOUR CHILD'S NAME HERE

____
PRINT PARENT/GUARDIAN NAME

____
YOUR CHILD'S AGE

____
PARENT/GUARDIAN SIGNATURE

____
DATE

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13		☐1/20	15
☐14-15		**☐1/15**	20
☐16-17		☐1/10	30
		☐2/15	40

MA 200 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/10	20
☐24-25		☐2/10	30
☐26-27		☐2/10	40
☐28-29		☐1/4	50
☐30-31		☐4/10	75
☐32-33		☐1/2	90
☐34-35		☐8/10	120
☐36-37		☐1	150

MA 200 Size 14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19		☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 200 Size 14x17

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	**☐1/10**	20
☐16-17		☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 200 Size 8x10

Other View _______________

CM_________ Kvp ________

MAS________ MA________

Size

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐88	☐1/4	40
☐30-31	☐88	☐3/10	50
☐32-33	☐88	☐2/5	70
☐34-35	☐88	☐1/2	90
☐36-37	☐90	☐3/5	120
☐38-39	☐92	☐4/5	160
☐40-41	☐94	☐1	200
☐42-43	☐96	☐1 1/2	
☐ 44-45	☐ 98	☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐80	☐2/10	40
☐22-23	☐80	☐1/4	50
☐24-25	☐80	☐4/10	75
☐26-27	☐80	☐1/2	90
☐28-29	☐80	☐4/5	120
☐30-31	☐80	☐4/5	150
☐32-33	☐80	☐4/5	120
☐34-35	☐80	☐1	170
☐36-37	☐80	☐1	210
☐38-39	☐80	☐1 1/2	
☐40-41	☐82	☐2	
☐42-43	☐ 82	☐2	
☐ 44-45	☐ 84	☐3	

MA 200 Size 14x17

Notes: ____

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____

CA Initials:

____

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: ____
FIRST MIDDLE LAST

GUARDIAN PHONE: Home__________________ Cell______________________ Work_________________

GUARDIAN SOCIAL SECURITY #: _________________ CHILD SOCIAL SECURITY #:__________________

DATE OF BIRTH OF GUARDIAN: ____________________

OTHER CONTACT IN CASE OF EMERGENCY: ________________________ Phone #: ________________

NAME OF PRIMARY INSURANCE CARRIER: ____

Name of Insured________________________ Insured Date of Birth _________________

Insured Social Security Number _________________

NAME OF SECONDARY INSURANCE CARRIER: ____

Name of Insured________________________ Insured Date of Birth _________________

Insured Social Security Number: _________________

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $40 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Samuel Stewart, DC or Clare Stewart, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_______________________________________ **Date**________________

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

____________________________ **(Signature)** __________________ **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

____________________________ **(Signature)** __________________ **(Date)**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

____

PRINT PRACTICE MEMBER'S NAME HERE

____ ______________________

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

____ ______________________

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

____

RELATIONSHIP TO MINOR/CHILD

____ ______________________

WITNESS SIGNATURE (OFFICE STAFF) **DATE**