Dakota Chiropractic
making your health a priority

CHILD
PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary **AND** secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

CHILD'S FIRST NAME _____ CHILD'S LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FUTURE APPOINTMENT TEXT REMINDERS? ◯ Y ◯ N CELL PHONE PROVIDER _____

EMAIL _____ *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY _____ ◯ M ◯ F GENDER SOCIAL SEC. XXX-XX-XXXX _____

MOTHER'S NAME _____ PHONE _____ SOCIAL SEC. XXX-XX-XXXX _____

FATHER'S NAME _____ PHONE _____ SOCIAL SEC. XXX-XX-XXXX _____

INSURED'S NAME _____ INSURED'S BIRTH DATE MM|DD|YYYY _____

INSURED'S EMPLOYER _____ OCCUPATION _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ GOOGLE ◯ LOCAL BEST ◯ DR. MCCOY ◯ DR. STEEVER

◯ EXISTING PATIENT _____ ◯ ANOTHER PROVIDER _____

2 EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO YOU _____ PHONE _____

PRIMARY DOCTOR/CLINIC _____ PHONE _____

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

AUTHORIZATION FOR CARE OF MINOR

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

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PATIENT NAME (PRINT) _____ DATE _____

1. **Describe your symptoms** _____

When did your symptoms start? _____

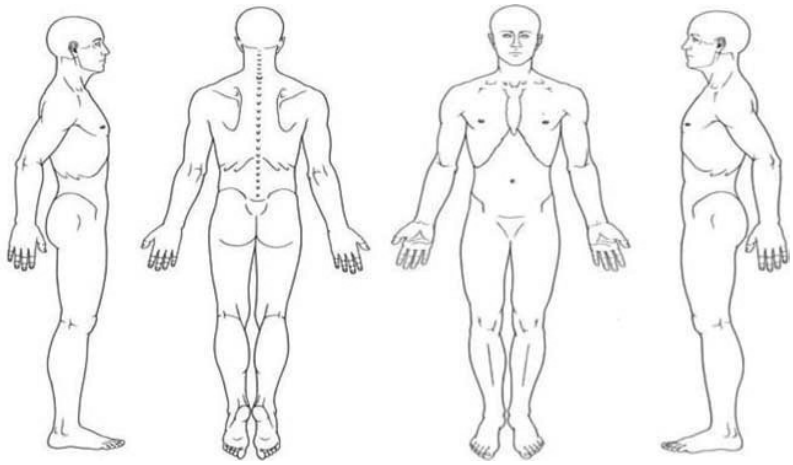
How did you symptoms begin? _____

2. **How often do you experience your symptoms?**
   - ◯ Constantly (76-100% of the day)
   - ◯ Frequently (51-75% of the day)
   - ◯ Occasionally (26-50% of the day)
   - ◯ Intermittently (0-25% of the day)

3. **What describes the nature of your symptoms?**
   - ◯ Sharp ◯ Shooting
   - ◯ Dull ache ◯ Burning
   - ◯ Numb ◯ Tingling

4. **What describes the nature of your symptoms?**
   - ◯ Getting Better
   - ◯ Not Changing
   - ◯ Getting Worse

Indicate where you have pain or other symptoms



5. **During the past 4 weeks:**
   Indicate the average intensity of your symptoms

NONE ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ UNBEARABLE

How much has pain interfered with your normal schedule? (Including work and home)
◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

How much of the time has your condition interfered with your social activities?
◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

6. **In general would you say your overall health is right now.**
   ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

7. **Who have you seen for your symptoms?** ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other
   What treatment did you receive and when? _____

   What tests have you had for your symptoms? ◯ Xrays DATE _____ ◯ CT Scan DATE _____
   ◯ MRI DATE _____ ◯ Other DATE _____

8. **Have you had similar symptoms in the past?** ◯ Yes ◯ No
   If you have received treatment in the past for the same or similar symptoms, who did you see? ◯ This Office ◯ Medical Doctor ◯ Other ◯ Chiropractor ◯ Physical Therapist

9. **What is your occupation?** ◯ Professional/Executive ◯ Trades Person ◯ Homemaker ◯ Retired ◯ White Collar/Secretarial ◯ Laborer ◯ FT Student ◯ Other

   If you are not retired, a homemaker, or a student, what is your current work status?
   ◯ Full-time ◯ Part-time ◯ Self-Employed ◯ Unemployed ◯ Other

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What type of regular exercise do you perform? ◯ None ◯ Light ◯ Moderate ◯ Active

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs

FEET INCHES

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
◯	◯	Headaches	◯	◯	High Blood Pressure	◯	◯	Diabetes
◯	◯	Neck Pain	◯	◯	Heart Attack	◯	◯	Excessive Thirst
◯	◯	Upper Back Pain	◯	◯	Chest Pains	◯	◯	Frequent Urination
◯	◯	Mid Back Pain	◯	◯	Stroke	◯	◯	Smoking/Use Tobacco
◯	◯	Low Back Pain	◯	◯	Angina	◯	◯	Products
◯	◯	Shoulder Pain	◯	◯	Kidney Stones	◯	◯	Drug/Alcohol Dependence
◯	◯	Elbow/Upper Arm Pain	◯	◯	Kidney Disorders	◯	◯	Allergies
◯	◯	Wrist Pain	◯	◯	Bladder Infection	◯	◯	Depression
◯	◯	Hand Pain	◯	◯	Painful Urination	◯	◯	Systemic Lupus
◯	◯	Hip/Upper Leg Pain	◯	◯	Loss of Bladder Control	◯	◯	Epilepsy
◯	◯	Knee/Lower Leg Pain	◯	◯	Prostate Problems	◯	◯	Dermatitis/Eczema/Rash
◯	◯	Ankle/Foot Pain	◯	◯	Abnormal Weight Gain/Loss	◯	◯	HIV/AIDS
◯	◯	Jaw Pain	◯	◯	Loss of Appetite			**Females Only**
◯	◯	Joint Swelling/Stiffness	◯	◯	Abdominal Pain	◯	◯	Birth Control Pills
◯	◯	Arthritis	◯	◯	Ulcer	◯	◯	Hormonal Replacement
◯	◯	Rheumatoid Arthritis	◯	◯	Hepatitis	◯	◯	Pregnancy
◯	◯	General Fatigue	◯	◯	Liver/Gall Bladder Disorder			**Other Health Issues**
◯	◯	Muscular In-coordination	◯	◯	Cancer	◯	◯	_____
◯	◯	Visual Disturbances	◯	◯	Tumor	◯	◯	_____
◯	◯	Dizziness	◯	◯	Asthma	◯	◯	_____
			◯	◯	Chronic Sinusitis			

Indicate if any immediate family member has had any of the following:

◯ Rheumatoid Arthritis ◯ Heart Problems ◯ Diabetes ◯ Cancer ◯ Lupus ◯ Other _____

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all surgical procedures and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

Doctor's Additional Comments

DOCTOR SIGNATURE _____ DATE _____

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FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in-network benefits. Until this information is provided to us, we require you to pay all co-pays, deductibles and/or co-insurance relating to out-of-network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. We require payment for any pre-set copays or non-insurance cases at the time of service. Deductible policies require you to pay $100 for the New Patient visit. You may pay the estimated deductible/co-insurance charges at time of service if you wish to avoid a statement in the mail.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at Dakota Chiropractic & Wellness Center, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with Dakota Chiropractic & Wellness Center.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Although these are rare, they include but are not limited to, muscle sprain/strain, dislocations, fractures, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Although our patients are screened for indications that they are candidates for chiropractic manipulation to the best of our ability, I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s). Therefore, the doctor based upon the facts then known, will act in the best interest of the patient. I understand that I can terminate treatment at any time, even during the course of any of the chiropractic procedures listed above.

PARENT/GUARDIAN NAME (PRINT) _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____