At Last Chiro - Member Form

At Last Chiropractic
5613 Skytop Drive
Lithia, FL 33547
(813) 461-6500

Intro

Welcome! This is what you can "expect" in your upcoming visit's.

PAPERWORK

Please complete this simple admittance Form so we have an understanding of your past and current health situation.

CONSULTATION

You will meet the doctor and discuss your health concerns.

EXAMINATION

We will conduct a thorough examination to locate the cause of your problem and determine if you are a candidate for chiropractic care. This includes a computerized assessment of how well your nervous system is communicating with your body. The assessment will include range of motion, surface electromyography, which evaluates muscle function and balance and an orthopaedic assessment. The doctor may also need additional procedures, such as x-rays. If yours is a chiropractic case, we will develop a plan to help you.

REPORT OF FINDINGS

During your second and third visits, the doctor will explain the results of your examination. If we think that we can help you, we will recommend a schedule of care created just for you. During this time we will also explain our financial policies and determine your insurance coverage, if applicable.

HEALTH TALK

We find that when patients are empowered to help themselves, they respond faster to care and remain healthier longer. If we decide to accept your case part of your care involves an opportunity to attend our health talk entitled health and healing and inside out approach.

Please complete the following pages to save time and help us to serve you better. Thank you.

Info

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Child's Name_____

_____ Birthday_____

Age_____ Weight ____ Male Female Height _____

Address: _____

City_____ State _____ Zip _____

Parent/Guardian _____

Home Phone_____ Cell Phone_____

Cell Phone Provider Verizon AT&T T-Mobile Sprint Other

_____

Email_____

How did you hear about At Last Chiropractic? _____

Who may we thank for referring you?_____

Reason for pursuing care: Maintenance Improve health Problem:

_____

Family History:_____

Check any of the following conditions that currently apply: Ear infections Scoliosis Chronic colds Headaches

Digestive problems Allergies ADD/ADHD Recurring fevers Growing pains Colic Seizures

Temper tantrums Bed wetting Asthma Car accident:

_____

Other

_____

Other doctors seen for this condition (Please include doctor?s names and prior treatment): _____

Previous Chiropractic Care? Yes No

_____

Name of Pediatrician: _____

Are you satisfied with the care your child has received at the pediatrician? Yes No

# of Doses of antibiotics your child has taken:Past 6 months

_____

Total lifetime

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Current prescription drugs & dosage: _____

Past prescription drugs & dosage: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.):_____

History

Prenatal History

Name of Obstetrician/Midwife:_____

Complications during pregnancy/delivery? Yes No

Ultrasounds during pregnancy? Yes No

Medications taken during pregnancy/delivery? Yes No

Cigarette/Alcohol use during pregnancy? Yes No

Location of birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: Emergency Planned

Genetic disorders/disabilities? Yes No

Birth Weight: _____ Birth Height: _____ APGAR Scores:_____

Feeding History

Breast Fed: Yes No

Formula Fed: Yes No_____ Type:_____

Introduced to:Solid Foobs @

Cow's milk @

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Food/Juice allergies or in tolerances:: Yes No

Developmental History

Your child?s spine is vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of neuro-structural shifts. The following can be affected by neuro-structural shifts. At what age was your chi

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Respond to stimuli _

Cross Crawl _

Stand alone _

Sit up _

Respond to visual stimuli _

Hold head up _

Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did your child have a fall similar to what was described above?

yes No

Other traumas not described above (bike fall, trampoline injury, etc.)?_____

Has your child been involved in any sports? Yes No

Has your child been seen by a physician on an emergency basis? Yes No

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Lifestyle

(please check all that apply):

Does your child: Eat healthy food (organic products, etc.) Drink water Take probiotics Take vitamins

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Exercise: none mild moderate heavy daily

Hobbies/ interests: _____

Is there anything else you would like us to know about your child?_____

Consent

By signing below, I am acknowledging that I am a parent/guardian of the above child, and I have filled out all the above accurately and to the best of my ability.

PLEASE READ CAREFULLY

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that Chiropractic care is considered very safe with an extremely low-risk rate. I further understand that there are, however, some risks associated with chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

In particular, I understand that in rare cases there have been reported incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapists, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements, including turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to a stroke. The risk of stroke after cervical adjustment is estimated at 1 in 1,000,000, substantially lower than that associated with any medical or other treatment medications or procedures for the same symptoms. To put this in perspective, studies that have assessed the risk from interventions a non-Chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries for neck pain: 15,600 per million

Risk of death from surgeries for neck pain: 6,900 per million

Risk of serious gastrointestinal event from non-steroidal

anti-inflammatory drugs: 1,000 per million

I understand that while rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments. I also understand that there have been rare reported cases of disc injuries following cervical and lumbar adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused by chiropractic treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I have read and understood the above, and I have had sufficient opportunity to discuss its content with the Doctor of Chiropractic indicated below. I do hereby request and consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic indicated below, for my present condition and for any future conditions for which I may seek care. I also agree to payment for all services rendered.

Parent/Guardian Signature