



**Child Entrance Forms**

PLEASE FILL OUT COMPLETELY- PLEASE PRINT

**PERSONAL INFORMATION**

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Parent Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_ Gender  Male  Female

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

**CURRENT PRIMARY HEALTH CONCERN**

What is your child's main symptom? \_\_\_\_\_

How long has he/she had this condition? \_\_\_\_\_

Has he/she had this condition in the past? \_\_\_\_\_

What seemed to have caused this condition? \_\_\_\_\_

What position(s), if any, make it feel worse? \_\_\_\_\_

What position(s), if any, make it feel better? \_\_\_\_\_

Over time, is this condition:  Improving  Unchanged  Getting Worse?

Is this condition interfering with:  Sleep  Daily Routine  Other: \_\_\_\_\_

**Average pain intensity:**

Last 24 hours: **no pain** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

Past week: **no pain** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

**How often does your child experience symptoms?**

- ① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

**How much has your child's symptoms interfered with his/her daily activities?**

- ① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

**In general, would you say your overall health right now is...**

- ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Has your child sought advice or treatment from other doctors or therapist for this condition?  Yes  No

Has your child been seen by a Doctor of Chiropractic before?  Yes  No If so, when? \_\_\_\_\_

Who is your family medical doctor/pediatrician: \_\_\_\_\_ Location: \_\_\_\_\_

## REVIEW OF SYMPTOMS

Has your child ever suffered from: *Please check all that apply.*

### **Ears:**

- Decreased hearing
- Ringing in ears
- Earache
- Drainage

### **Nose:**

- Chronic discharge
- Itching
- Hay fever
- Chronic nosebleeds
- Sinus pain

### **Throat:**

- Bleeding
- Soreness
- Hoarseness
- Thrush
- Non-healing sores

### **Neck:**

- Lumps
- Swollen glands
- Pain
- Stiffness

### **General:**

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

### **Skin:**

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair & nail changes

### **Head:**

- Headache
- Head injury

### **Eyes:**

- Pain
- Redness
- Blurry or double vision
- Visual disturbances
- Glaucoma
- Cataracts

### **Breasts:**

- Lumps
- Pain
- Discharge

### **Respiratory:**

- Cough
- Sputum
- Coughing up blood
- Shortness of breath
- Wheezing
- Painful breathing

### **Cardiovascular:**

- Chest pain
- Tightness
- Palpitations
- Shortness of breath
- Difficulty breathing
- Swelling
- Sudden awakening of sleep from shortness of breath

### **Gastrointestinal:**

- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- Yellow eyes or skin

### **Urinary:**

- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in strength

### **Vascular:**

- Calf pain with walking
- Leg cramping

### **Hematologic:**

- Ease of bruising
- Ease of bleeding

### **Neurologic:**

- Dizziness
- Fainting
- Seizures
- Numbness
- Tingling
- Tremor

### **Endocrine:**

- Heat or cold intolerance
- Sweating
- Thirst

### **Psychiatric:**

- Nervousness
- Stress
- Depression
- Memory loss

## MEDICAL HISTORY

Please list all surgeries/hospitalizations:  None

Date:

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Please list all accidents/falls/injuries:  None

Date:

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Please list all medications:  None

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Doctor's Notes:

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## OFFICE FEES AND FINANCIAL POLICY

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees; therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the option that you would prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you. If you would like a copy of our full fee schedule, please ask and we would be happy to provide that for you.

**Insurance:** We will verify all insurance and your benefits per your agreement with your carrier. If your insurance covers any or all of care, it will be posted to your account accordingly. Any charge for services NOT covered by insurance is the **patient's** responsibility and will be billed out monthly.

**Same Day Discount Policy:** Any account considered a CASH account qualifies for same day discount, based on services rendered. All charges must be paid in FULL on the date of service to receive the discount. Any charges not paid on the same day will be billed at the usual service fee. The initial same day cash fee for new patients, which includes the consultation, examination, and any necessary treatment, is **\$76**. Subsequent office visit charges will be **\$40**.

## PARENT/LEGAL GUARDIAN INFORMATION

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

**Agreement:** My signature below signifies my understanding that I will be responsible for any charges for services that are not covered by my insurance.

I would like to receive paperless billing at email: \_\_\_\_\_

I have read and agree to the above statement.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

## AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my child through the use of adjustments to his/her spine, as he deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



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### **Acknowledgement for consent to Use and Disclosure of Protected Health Information**

#### **Use and Disclosure of your Protected Health Information**

Your protected health information will be used by NCRC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office.

#### **Notice of Privacy Practices**

You should review the notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy \_\_\_\_\_ Patient Initials

#### **Requesting a Restriction on the Use of Disclosure of Your Information**

- You may request a restriction on the use or disclosure of you Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Notice of Some Treatment in Open or Common Areas**

Private therapy areas available upon request.

#### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name