LIFEPOINTE CHIROPRACTIC & WELLNESS CENTER
248-623-6107

DATE: _____ ID #: _____

PEDIATRIC NEW PATIENT INFORMATION

Welcome to our office

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ Age: _____ Sex: M / F Birthdate: _____

Address: _____ City/State/Zip: _____

Home phone: ( )_____

Mother's Name: _____ Cell Phone #: _____

Father's Name: _____ Cell Phone #: _____

How did you hear about our office? _____

Purpose for contacting us: ☐ Optimal Health Check-up ☐ Specific Health Concern or Challenge

Please explain: _____

Other doctors seen for this condition: Y / N Prior Treatments: _____

_____

Previous Chiropractor: _____ Date of last visit: _____

Name of Pediatrician: _____ Date of last visit: _____

Reason: _____

Height: _____ Weight: _____

What type of delivery did your child have? ☐ vaginal ☐ C-section

Location of birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other: _____

Birth Intervention: ☐ Medication ☐ Forceps ☐ Vacuum extraction ☐ Other: _____

Were there any complications during pregnancy/delivery? Y / N

Explain: _____

Number of doses of antibiotics your child has taken: During the past six months: _____ Total during his/her lifetime: _____

Vaccination history: _____

Adverse reactions: ☐ Fever ☐ High-pitched screaming ☐ Redness at injection site ☐ Seizure ☐ Lethargy
☐ Diarrhea ☐ Behavioral Changes ☐ Other: _____

List all medications your child is currently taking: _____

_____

List all supplements your child is currently taking: _____

_____

Does your child have food allergies/sensitivities? Explain: _____

Please continue to next page

Circle any of the following conditions your child has suffered from during the past six months:

Ear Infections ☐	Scoliosis ☐	Seizures ☐	Chronic Colds ☐	Headaches ☐
Asthma/Allergies ☐	ADHD/ADD ☐	Recurring Fevers ☐	Digestive Problems ☐	Growing Pains ☐
Car Accident ☐	Bed Wetting ☐	Temper Tantrums ☐	Colic ☐	Behavior Problems ☐
Autism ☐	Neck Pain ☐	Back Pain ☐	Reflux ☐	Other:_____
Poor Posture ☐	Trouble Walking ☐	Sleeping Problems ☐	Poor Appetite ☐	

According to the National Safety Council, approximately 50% of all children fall head-first from a high place during their first year of life (a bed, changing table, down stairs, etc.). Was this the case with your child? Y / N If yes, what happened? _____

_____

Is/has your child been involved in any high-impact or contact type of sports (soccer, football, gymnastics, baseball, cheerleading, hockey, martial arts, etc.) Y / N Please list: _____

What other hobbies or activities does your child participate in? _____

Has your child ever been involved in a car accident? Y / N List: _____

Has your child ever been seen on an emergency basis? Y / N Explain: _____

Has your child ever broken a bone? Y / N Concussion(s)? Y / N

Other traumas not listed above: Y / N List: _____

Prior surgeries: Y / N List: _____

Does your child have high energy? Y / N

Do you feel your child is as healthy as he/she can be? Y / N

Is there any other information you would like to share at this time? _____

_____

_____

Please continue to next page

FINANCIAL INFORMATION

Do you have health insurance? ○ Yes / ○ No With whom? _____

If yes, what is your relationship to the insured? ○ SELF ○ SPOUSE ○ CHILD ○ OTHER _____

(If the insured is someone other than yourself, please complete the information below).

Insured's Full Name: _____ Insured's Date of Birth: _____

Financial Responsibility: I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lifeppointe Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company. HOWEVER, I clearly understand and agree that I am personally responsible for any payment.

CONSENT FOR TREATMENT/TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column that interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. Our chiropractic method of correction is specific adjustments of the spine. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, the undersigned, a patient in this office, hereby authorize LIfepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of chiropractic. I also certify that no guarantee or assurance has been made to the results that may be obtained. I have read and fully understand the above statements, and accept chiropractic care on this basis.

Consent for a minor (if applicable): I, the undersigned, hereby authorize Lifepointe Chiropractic Center to administer treatment as necessary, if needed, within the lawful scope of Chiropractic to my child
(Name: _____).

NOTICE OF PRIVACY PRACTICES

I understand the posted "Notice of Privacy Practices for Protected Health Information" describing how my medical information may be used and disclosed, and how I can get access to this information. (A copy of this document is available to me at any time.)

The above information is true and accurate to the best of my knowledge, and I understand and agree to the statements above.

Patient/Guardian signature: _____ Date: _____