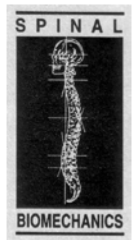

Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

CHILD AS PATIENT INFORMATION

Date____________________________

Child's Name____
(First) (Initial) (Last) (Nickname)

Address ____

City__________________________ State__________ Zip_______ Birthday___________ Age:______ ☐ Male ☐ Female

Mother _________________________________ Address __________________________ City_______ State____ Zip______

Father _________________________________ Address __________________________ City_______ State____ Zip______

Insurance Company____Employer________________________________

Subscriber Name ____ Birthday___________________
(First) (Initial) (Last)

Please present insurance card(s) so we can put a copy in your file.

CONTACT INFORMATION

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email **Home phone** ____________________________

Cell phone ____________________Work phone ____________________ Ext _____ Email_____________________________

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr.___________________________________ to administer care as deemed necessary to my son/daughter, ____ (Print Child's Name)

Signed____Date______________________________

Witnessed Date

AUTHORIZATION TO TAKE AND PUBLISH PHOT0GRAPHS

I, ____authorize Dr.________________________ or another person authorized by Him/her to take and publish photographs of my child, for clinical records. Such photographs may be used in publications scientific and /or clinical research, chiropractic education, and for the purpose of promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization

Signed____Date______________________________

Witnessed Date

Dear Parent(s);

Today, we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxafions.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Supluxafion Complex. Correction of the Subluxafion with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

To assist in this spinal analysis please complete the questionnaire on the following page.

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Childs Name				Birth Date	
This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.					
Has your child been checked by a Doctor of Chiropractic?				☐ No ☐ Yes	
Who?				Were x-rays taken? ☐ No ☐ Yes	
Who is your regular pediatrician?					
Experts around the world agree: the birth process as we know it may cause trauma, damage and even death to the infant.					
Did you have ultrasound during pregnancy? ☐ No ☐ Yes				Frequency	
Place of birth:	☐Home	☐Birthing Center	☐Hospital	☐Other	
Provider	☐Midwife	☐OB-Gyn	Type of Birth:	☐Vaginal	☐C-section
Was anesthesia used? ☐ No ☐ Yes			Type?		
Was labor induced? ☐ No ☐ Yes			If yes, why?		
What position did you deliver in:			☐On Back		☐Squatting
Birth Trauma	☐Doctor assisted	☐Twisting	☐Pulling	☐Forceps	☐Vacuum Extraction
Newborn trauma (medical procedures and tests)					
Did you breast-feed your child? ☐ No ☐ Yes			How long?		
Was your decision supported by your health care provider? ☐ No ☐ Yes					
According to the National Safety Council – approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually.					
Can you recall any such jolts, falls or traumas to your child? ☐ No ☐ Yes					
Please Describe					
Any fractures or dislocations? ☐ No ☐ Yes					
Which sports does your child play?			☐Lacrosse	☐Dance	☐Swimming
☐Soccer	☐Gymnastics	☐Karate	☐Hockey	☐Baseball	☐Basketball
☐Football	☐Trampoline	☐Wrestling	☐Tennis	☐Other	☐Golf
Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting?					
Additional hrs sitting			Is it in front of a computer or TV? ☐ No ☐ Yes		
How would you rate your child's diet?			☐Excellent	☐Fair	☐Poor
Does your child consume artificial sweeteners? ☐ No ☐ Yes				Fluoridated water? ☐ No ☐ Yes	
Check any of the following conditions your child has suffered from :					
☐Irregular Sleeping Patterns		☐Night Terrors	☐Colic	☐Seizures	☐Learning Disorders
☐Repeated Infections or Colds		Ear Infections	☐Headaches	☐Asthma	☐Emotional Disorders
☐ADD / ADHD	☐Bed Wetting	☐Migraines	☐Tantrums	☐Allergies	☐Poor Digestion
How often has your child been treated with drugs?					
Were you informed of their adverse reactions? ☐ No ☐ Yes					
If it was an antibiotic, was your child cultured for its use? ☐ No ☐ Yes					
Is your child currently on any medications? (please list)					
Has your child had any surgeries?					
The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child?					
Did your child experience behavioral, emotional or physical changes within 3 months after any shots? ☐No☐Yes					
Describe					
Was it reported by you or your doctor? ☐ No ☐ Yes					

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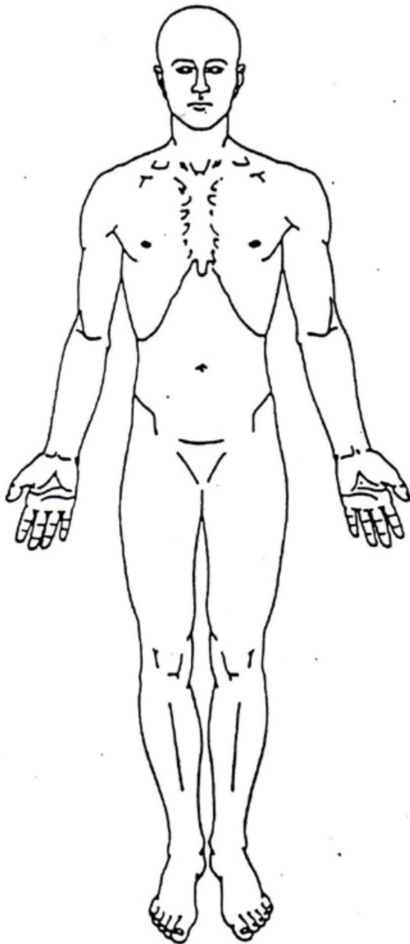
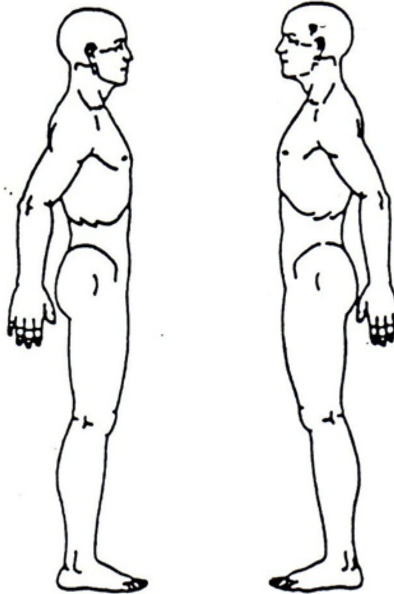
DIAGRAM OF PATIENT'S DISCOMFORT

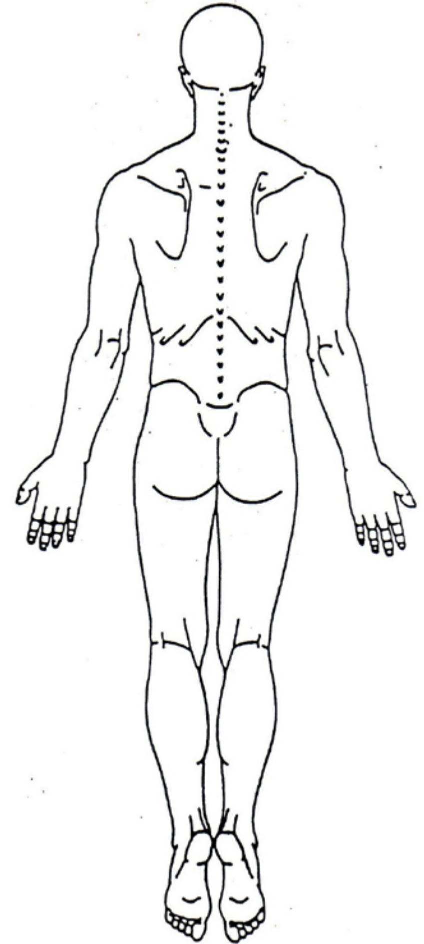
Name		Date
Habits		
☐ Smoke - packs /day	☐ Coffee - Cups/day	☐Alcohol - Amount/day
Exercise		
☐ None ☐ Moderate ☐ Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		☐ Yes ☐ No
☐ Over the counter	☐ From my doctor	☐ I send away for them
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)										
1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

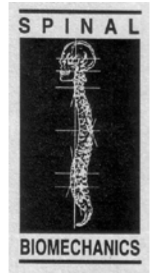
Use these figures to mark your pain







Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other



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HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

☐ HOME TELEPHONE: ________________________________

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

OR

☐ N0, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.

☐ If necessary may we call you at work? If yes, list number_____________________________

Signature of patient__________________________________ Date _________/____/__________
or legal proxy