Express Life CHIROPRACTIC

CHILDREN'S HEALTH HISTORY FORM

Today's date _____

ABOUT THE CHILD

Name _____ Age_____ Date of birth _____

Gender – please circle one: Male Female Height _____ Weight _____

Home address _____ City _____ State _____ Zip _____

PARENT/GUARDIAN A	PARENT/GUARDIAN B
Name _____	Name _____
Home phone _____	Home phone _____
Cell phone _____	Cell phone _____
Employer _____	Employer _____
Email _____	Email _____

Name(s) and Age(s) of your child's sibling(s): _____

Select which is true for your child: ☐ Self Pay ☐ Insured (If insured, driver's license and insurance card copy needed)

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Express Life Chiropractic can address for your child? _____

_____

Related to: Sports Auto Fall Chronic Home Injury Other: _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Circle any being affected:

- □ School
- □ Playing
- □ Communication
- □ Exercise/sports
- □ Sleep
- □ Eating
- □ Walking
- □ Attention/focus
- □ Daily routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from chiropractic care:

Check all that apply:

- □ Symptomatic relief of pain or discomfort
- □ Correction of the cause of the problem as well as relief of symptoms
- □ Prevention of future problems
- □ Healthier spine and nerve system
- □ Optimal health on all levels
- □ Other _____

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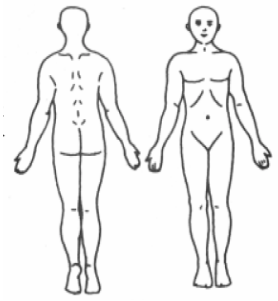


#1 COMPLAINT

What is your main health concern for your child: _____

Is it: ☐Job Related ☐Auto Accident ☐Fall ☐Home Injury ☐Other: _____

When did this condition begin? ☐___Days ☐___Weeks ☐___Months ☐___Years

Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Burning

☐Tender ☐Stiff ☐Numb ☐Tingling ☐Excruciating

When do they experience their symptoms: ☐Morning ☐Afternoon ☐Night ☐Constant

☐Comes & Goes During the Day ☐Increased During the Day ☐Decreases During the Day ☐During Sleep

On a scale of 1 (minimal) – 10 (extreme): Please rate their pain RIGHT NOW: ____ **AT ITS WORST:** _____

What activities aggravate their condition? _____

What activities lessen their condition? _____

Does their pain travel to another location? Y / N If Yes, Where? _____

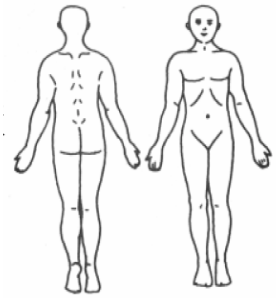
Is this condition interfering with: ☐Sleep? ☐Routine? ☐Other: _____

Have you seen other doctors for this concern? Y / N **What did they recommend:** _____

Additional information you feel your Doctors should know: _____

_____

_____



#2 COMPLAINT (If you do not have a 2nd complaint, please check here ☐ and skip to next section)

What is your main health concern for your child: _____

Is it: ☐Job Related ☐Auto Accident ☐Fall ☐Home Injury ☐Other: _____

When did this condition begin? ☐___Days ☐___Weeks ☐___Months ☐___Years

Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Burning

☐Tender ☐Stiff ☐Numb ☐Tingling ☐Excruciating

When do they experience their symptoms: ☐Morning ☐Afternoon ☐Night ☐Constant

☐Comes & Goes During the Day ☐Increased During the Day ☐Decreases During the Day ☐During Sleep

On a scale of 1 (minimal) – 10 (extreme): Please rate their pain RIGHT NOW: ____ **AT ITS WORST:** _____

What activities aggravate their condition? _____

What activities lessen their condition? _____

Does their pain travel to another location? Y / N If Yes, Where? _____

Is this condition interfering with: ☐Sleep? ☐Routine? ☐Other: _____

Have you seen other doctors for this concern? Y / N **What did they recommend:** _____

Additional information you feel your Doctors should know: _____

_____

_____

Additional Complaints: _____

_____

_____

_____

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PREGNANCY & BIRTH

During pregnancy, did the mother:
Experience any significant illnesses, difficulties, or trauma? _____
Take any drugs/medications? _____
Smoke or consume alcohol? _____

HOME BIRTH HOSPITAL BIRTH VAGINAL WATER BIRTH CAESAREAN EMERGENCY-C

Child's Birth Weight: _____lbs. _____ oz. Birth Height: _____ft. _____ in. APGAR SCORE _____

Was the delivery premature? NO YES WEEKS_____ WEIGHT_____

Approximately, how long did labor last? ____ HOURS Was labor artificially induced? NO YES _____

Was it determined that the child was breech or other malpositioned? NO YES _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

- □ EPIDURAL
- □ PITOCIN
- □ FORCEPS
- □ EPISIOTOMY
- □ VACUUM
- □ MANUAL TRACTION OF THE NECK
- □ MEDICATIONS _____ _____

Please check all that apply to the baby's state immediately after birth:

- □ JAUNDICE
- □ FEEDING PROBLEMS
- □ RESPIRATORY PROBLEMS
- □ DISPLACED JOINTS
- □ BROKEN BONES
- □ OTHER CONDITIONS

Was the baby breastfed? YES - FOR HOW LONG? _____ NO - WAS THIS DUE TO A COMPLICATION? _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes in contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? NO YES ☐ Delayed Schedule ☐ On Schedule

Please describe any and all reactions to vaccine(s) _____

Please check all that apply and give any necessary details

- □ Child exposed to second hand smoke _____
- □ Has taken antibiotics. Explain _____
- □ Currently taking medication. Explain _____
- □ Currently taking supplements. Explain _____
- □ Has allergies. Explain _____

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PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

- □ Uncoordinated/Accident prone _____
- □ Has been hospitalized _____
- □ Had a severe trauma _____
- □ Been in an automobile accident _____
- □ Has fractured a bone or dislocated a joint_____
- □ Has/had a chronic illness _____
- □ Has had surgery _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS If child is under 3 years old, please check N/A ☐

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

- □ Academic pressure
- □ Lifestyle change
- □ Loss of a loved one
- □ Parents' divorce/separation
- □ Bullying
- □ Loss of a pet
- □ Relocation
- □ New sibling

Does your child have difficulty interacting with schoolmates or friends? YES NO

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? YES NO

HEALTH CARE PRACTITONER HISTORY

Has your child ever received chiropractic care? NO YES Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____
How often did they go?_____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Please check all that apply

- □ Medical Physician Reason _____
- □ Massage Therapist _____
- □ Naturopath _____
- □ Psychotherapist _____
- □ Acupuncturist _____
- □ Energy Healer _____
- □ Homeopath _____
- □ Other _____

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FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW

Please Print Your Child's Name Here _____ Date _____

CONDITION	CHILD	FATHER	MOTHER	SIBLING(S)
Arm Pain				
Arthritis				
Asthma				
ADD / ADHD				
Allergies				
Back Trouble				
Bed Wetting				
Cancer				
Carpal Tunnel				
Colic				
Depression				
Diabetes				
Digestive Problems				
Disc Problems				
Ear Infections/Hearing Loss				
Fibromyalgia				
Frequent Cold / Flu				
Headaches / Migraines				
Heartburn				
High / Low Blood Pressure				
Hip Pain				
Learning Disability				
Leg Pain				
Menstrual Disorder				
Neck Pain				
Sciatica				
Scoliosis				
Shoulder Pain				
Sinus Trouble				
Sleep Problems				
Thyroid Problems				
TMJ				
Vertigo / Dizziness				
Vision Problems				
Other:				

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PRACTICE MEMBER INFORMATION

(MUST BE COMPLETED BEFORE SERVICES CAN BE RENDERED)

CHILD'S FULL NAME _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____

CONTACT IN CASE OF EMERGENCY _____ PHONE NUMBER _____

NAME OF PRIMARY INSURANCE CARRIER _____

NAME OF INSURED _____ INSURED DATE OF BIRTH _____

INSURED SOCIAL SECURITY NUMBER _____

NAME OF SECONDARY INSURANCE CARRIER _____

NAME OF INSURED _____ INSURED DATE OF BIRTH _____

INSURED SOCIAL SECURITY NUMBER _____

INSURANCE POLICIES AND FEE SCHEDULE

Consultation: include practice member history. This service is complimentary.

Assessment (new or established practice member): includes one or more of the following: thermography, postural evaluation, range of motion, motion and/or static palpation, ortho/neuro testing, leg check.

Chiropractic Adjustment: The actual re-alignment of the vertebra done by hand or instrumentation. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.

X-rays: Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care.

*Fees for services vary depending on the individual's needs, recommendations and insurance coverage.

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Troy Hayes, DC. I agree that this authorization will cover all services rendered until I revoke that authorization. I agree that a photocopy of this form may be used in place of the original. I understand that all professional services rendered are charged to the patient and that it is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by the assignment and that Express Life Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I understand that any advertisement/promotional discount offered may not include the entire assessment as described above, chiropractic adjustment or necessary x-rays. Should I decide to proceed with any services not included in advertised/promotional discount, these services will be paid at the normal and customary fees as stated above. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice message, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Signature _____ **Date** _____

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TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authored by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structure and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question out the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ **Date** _____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE _____

DATE _____

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. TROY HAYES AND DR. ASHLEY HAYES AND ANY AND ALL EXPRESS LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY EXPRESS LIFE CHIROPRACTIC

DATE _____

PARENT OR GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD _____

WITNESS SIGNATURE (OFFICE STAFF) _____ DATE _____

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MEDIA RELEASE FORM

I, _____, grant permission to **Express Life Chiropractic**, hereinafter known as the "Media" to use my image (photographs and/or videos) for use in Media publications including: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Name (please print) _____ Date _____

Signature _____

Signature of parent or legal guardian _____
(if under 20 years of age)

ELC Staff _____