Elite Chiropractic Consent Form

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, and any other associated procedures on me by Dr. Scott Nigbor and Associates of Elite Chiropractic.

I understand, as with any other health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, soreness.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgments during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read the above explanation of chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment as Elite Chiropractic. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future treatment I seek.

_____ _____

Signature of Patient Date

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here-and most importantly, getting results!

Please check the circle that applies to you:

☐ Sure! You can use my pictures as long as I look good in it!

☐ No Thanks! I will pass for now.

_____

Printed name of Patient

_____

Signature of Patient Date

_____

**List family members this applies to as well

Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name:	Parent/Guardian Name(s):	
Street Address:	City, State, Zip:	
Cell Phone:	Other Phone:	Child's Sex: ○ M ○ F
Email:	Child's SS #:	Birthdate: Age:
How did you hear about us?		Weight: Height:
Who is your primary care physician?		
Is your child receiving care from any other health professionals? ○ Yes ○ No - If yes, please name them and their specialty:		
Please list any drugs/medications/vitamins/herbs/other that your child is taking:		

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition before? ○ Yes ○ No
- If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

○ Resolve existing condition
○ Overall wellness
○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what is their name?

What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutritional ○ Subluxation-based ○ Other: _____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues?	○ Yes ○ No	If yes, please explain:
Did mother smoke?	○ Yes ○ No	If yes, how many per week?
Did mother drink?	○ Yes ○ No	If yes, how many per week?
Did mother exercise?	○ Yes ○ No	If yes, please explain:
Was mother ill?	○ Yes ○ No	If yes, please explain:
Any ultrasounds?	○ Yes ○ No	If yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnacy:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____ Teethe:_____
Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGMENT & CONSENT

Patient Signature: _____ Date: _____