justice family chiropractic

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PEDIATRIC PATIENT INFORMATION

WELCOME TO JUSTICE FAMILY CHIROPRATIC. We specialize in assisting our patients to achieve their highest level of health through our nervous system and spinal corrective programs. Our approach is very unique and advanced from other chiropractic programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____
Patient's Name

_____
Parent Signature:

_____
Today's Date:

"Our Family Serving Yours"

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Parent's Name: _____

Parent's Occupation: _____ Employer Name: _____

Other Parent's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Other Parent's Employer: _____ Occupation: _____

How were you referred to this office? _____

INSURANCE INFORMATION

Primary Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Secondary Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

PURPOSE(S) OF THIS VISIT

Reason for this visit – Main Complaint(s):_____

_____

Is this purpose related to an auto accident: □ Yes □ No If so, when: _____

_____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate the condition/symptoms? _____

_____

Is there anything that has relieved the conditions/symptoms? □ Yes □ No Describe:_____

_____

Type of Pain (if present): Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Is this condition getting worse? □ Yes □ No Explain: _____

_____

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Rate the pain (if present) on Scale between 0-10, 10 being Severe Pain: Pain Right Now_____ At its Worst_____ At its Best _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

_____

Who have you seen for this? _____ What did they do? _____

How did the condition (symptom) respond? _____

Child's Health History

Child's birth was: At Home / In a Hospital / At a Birth Center : Which Facility: _____

My Obstetrician / Midwife / Family Physician was _____

Child's birth was: Natural Vaginal (no medications/interventions) / Vaginal with Intervention (medications, induction, Forceps, Vacuum)

C- Section Birth: Scheduled / Emergency – List reasons why _____

Child's birth weight and height_____ Current weight and height_____

Child's Hospitalization and Surgical History _____

_____

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

_____

Is/Was your child breastfed? Yes / No If Yes, how long? _____

Was formula ever introduced? Yes / No If Yes, at what age? _____

Introduction of Cow's Milk at age? _____ Introduction of Solid Foods at Age? _____

Briefly explain any difficulties during the pregnancy of this child _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

Any exposure to ultrasound? Yes / No if so how many and what was the medical reason ?_____

Has child received any vaccinations? Yes / No If yes which ones and list any reactions _____

_____

Has child received any antibiotics? Yes / No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? Yes / No If yes, please explain _____

_____

Any behavior problems? Yes / No If yes, please explain _____

_____

Current Medications? Past Medications Yes / No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? Yes / No If yes, please explain _____

_____

EXPERIENCE WITH CHIROPRACTIC

Have your child seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did he/she respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like your child carries their head forward, noticed a rounding of their shoulders or a developing "hump" at the base of their neck?

□ Yes □ No

HEALTH LIFESTYLE

Does the child take any supplements (i.e. vitamins, minerals?) _____

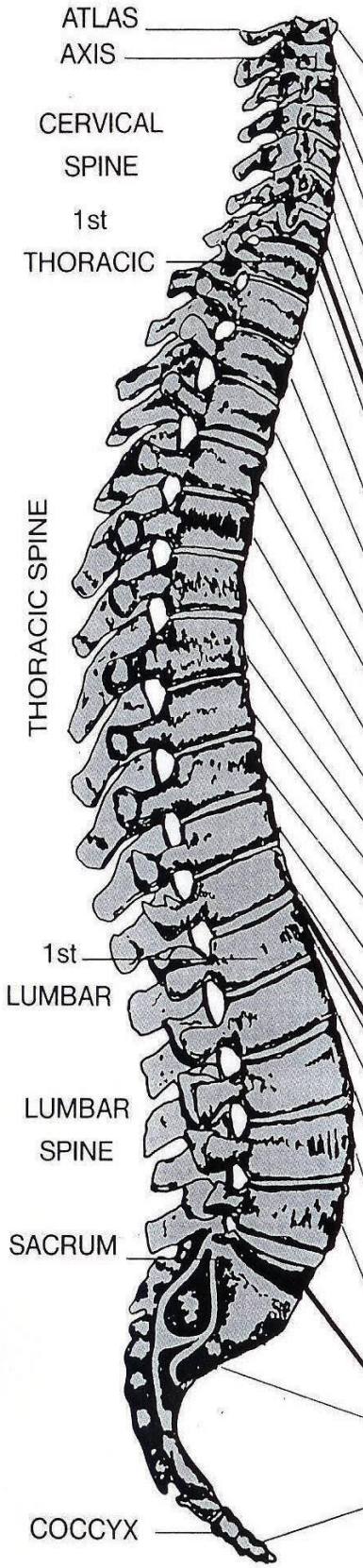
_____

Does the Child Exercise? Yes / No If yes, how so? _____

Please check any health condition your child may be experiencing, now or in the past, on the next page.

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy,* 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.



	Vertebrae	Areas Controlled by Nerves*	Please Check Below ↓ Possible Effects of a Malfunction
NECK REGION	1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
	2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.
	3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
	4C	Nose, lips, mouth, eustachian tube.	☐ hay fever, ☐ runny nose, ☐ hearing loss, ☐ adenoids.
	5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.
	6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.
	7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.
MID-BACK	1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.
	2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.
	3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
	4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
	5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.
	6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
	7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.
	8T	Spleen.	☐ lowered resistance.
	9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.
	10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
	11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.
	12T	Small intestines, lymph circulation.	☐ rheumatism, ☐ gas pains, ☐ certain types of sterility.
LOW BACK	1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.
	2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.
	3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.
	4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
	5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
PELVIS	SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.
	COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

CONSENT TO CARE

I do hereby authorize the doctors of Justice Family Chiropractic PLLC to administer such care that is necessary for my child's particular case. This care may include consultation(s), examination(s), spinal adjustments and other chiropractic procedures, including Insight scanning and diagnostic x-rays or any other procedure that is advisable, and necessary for my child's health care. I understand that all examination procedures, including x-rays, are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Furthermore, I authorize and agree to allow the Daniel Justice D.C. and Lindsay Justice D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my child's spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor(s) of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my child's health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my child's best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that my child will not receive the full benefit from the programs offered, and that if I terminate their care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my child's account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my child's present condition and for any future conditions(s) for which they seek treatment.

Parent/Guardian's Signature:_____ Date _____

FINANCIAL INFORMATION

I understand that all services rendered are my financial responsibility. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Justice Family Chiropractic will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. I also understand that if my insurance company requires pre-authorization of services or review of medical notes, that Justice Family Chiropractic will provide required documentation to my insurance company but I am financially responsible if my insurance chooses not to cover rendered services. Any monies received will be credited to my account. I certify that if this office visit is related to any personal injury or worker's compensation case that is active or that has not been closed I have noted this above.

Parent's (Guardian's) Signature:_____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1) The right to review the notice prior to signing this consent,
2) The right to object to the use of my health information for directory purposes, and
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Parent's (Guardian's) Signature: Date:

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

_____

_____

_____