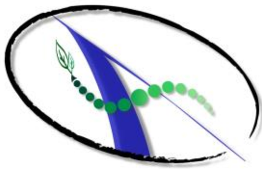

1900 Main St. Ste. D
Klamath Falls, OR 97601
(541)887-8555

Confidential Patient Information for Child

_____/_____/_____
DATE
________________________________ M ____ F____
NAME
_____/ _____/_____ __________ ____
BIRTHDATE AGE PARENTS NAME
____________________________________ ________________________________ _____________
HOME ADDRESS CITY ZIP
____
MAILING ADDRESS (if not same)
_______________ _________________________ ____________________________________
HOME PHONE PARENT CELL PHONE PARENT EMAIL

Method of Payment (circle): Cash/Card Ins Medicare Auto Ins Other

How did you learn of our office: yellow pages TV radio Internet Other:___________ referred by: ______________

Emergency Information
Who should we contact in case of an emergency? ____
__________________ _____________________ ____________________
Home Phone Work Phone Cell Phone

Health care providers
Family doctor: ______________________________ Clinic Name: ___________________________________

Other health professional (Nurse practitioner, Massage therapist, PT, OT, Naturopath, Homeopath, etc)
Name: ____ Type of provider: ______________________________

Name: ____ Type of provider: ______________________________

Has the child seen a chiropractor before? Y____ N____ If yes, results:____________________________

FAMILY HEALTH HISTORY
Indicate who in the family has the history M = mother, F = father, S = sibling, GP = grandparent

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease/Hepatitis
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Psychological problem type:______________________
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Immune disorder or disease
- ☐ Other:________________________

Wellness profile
The human body is designed to be healthy. The primary system which coordinates health is the nervous system which is protected by the spine. Many of the common health challenges that adults experience have their origins in the developmental years of childhood. Traumas, including birth, may lead to dysfunctional movement of the spine which can decrease health. Please answer the following questions to help us determine the signals that may indicate decreased health in your child.

Patient's Name:______________________________ DOB: ______________ Date:_____________

What signals has your child's body been communicating:

□ Asthma	□ Frequent diarrhea	□ Fail to thrive / slow weight gain
□ Respiratory tract infections	□ Constipation	□ Slow or absent reflexes
□ Sinus problems	□ Flatulence	□ Asymmetrical crawling or walking
□ Ear infections	□ Headaches	□ Weight challenges
□ Tonsillitis	□ Neck pain	□ Bed wetting
□ Strep throat	□ Torticollis / head tilt	□ Sleep problems
□ Frequent colds / croup	□ Trouble feeding on one side	□ Night terrors
□ Recurrent fevers	□ Back pain	□ Tip toe walking
□ Eczema	□ Growing pains	□ Regression of milestones
□ Rashes	□ Scoliosis	□ Seizures
□ Allergies	□ Red, swollen, painful joint	□ Tremors / shaking
□ Food sensitivities	□ Colic	□ ADD / ADHD
□ Digestive problems	□ Frequent crying spells	□ Autism

Do you have a specific concern that brought you to our office: No □ Yes □ If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? No □ Yes □ For how long? __________________

Is it getting better, worse, or staying the same? _______________ Was the onset sudden or gradual? ____________

What makes it better?_____________________________ What makes it worse?_______________________________

Have you seen other health care professionals for this? No □ Yes □ If yes, who? ___________________________

Types of treatment used: ____

Has your child taken any medication for this complaint……. No □ Yes □ _________________________________

Has your child experienced this before…………………… No □ Yes □ _________________________________

Did they receive any treatment at that time………………. No □ Yes □ _________________________________

Has your child had x-rays or other tests for this complaint… No □ Yes □ _________________________________

Prenatal History

Adoption □ Prental history unknown □ Birth history unknown □
Complications during pregnancy: No □ Yes □ Please explain: ____
Medications during pregnancy: No □ Yes □ If so, please list (including OTC): _________________
____
Exposure to alcohol, cigarettes, second hand smoke during pregnancy: No □ Yes □

Birth experience

Location of birth: Home □ Hospital □ Birthing center □ Other:_________________________
Delivery by: Midwife □ GP □ OB □ Other:__________________________________
Medications during labor and delivery (including IV antibiotics): No □ Yes □ ______________________________
Was Pitocin used to start or speed up delivery: No □ Yes □
Was your child at any time during pregnancy in an intra-uterine constrained position: No □ Yes □ Unsure □
If yes, please describe: Breech □ Transverse □ Face / brow presentation □
Was your deliver vaginal or C-section? ________________ If C-section, was it planned or emergency? _________
Were any interventions used during the delivery: Forceps □ Vacuum extraction □ Other □ _________________
Were there any complications during delivery? No □ Yes □ If yes, please explain _________________________
____
How long was the labor from first regular contraction to the birth? _______________ Hours
Any concerns with misshapen head at birth: No □ Yes □

Patient's Name:______________________________ DOB: _____________ Date:____________

Post natal & infant history

How many weeks gestation was the baby at birth? _____
Birth weight: ____ lbs____oz Birth length: ______in
Was the baby every admitted to neonatal intensive care: No □ Yes □ If yes, for how long and why:
____
Was any medication given to the baby at birth: No □ Yes □ If yes, what medication and why:
____
Was your child exclusively breastfed: No □ Yes □ _________months
Was your child fed formula: No □ Yes □ __________ months
Did you introduce cereal or grains in the first year: No □ Yes □
Did your child show any sensitivities to formula or solid foods: No □ Yes □ If yes, to what and the response
____

Physical traumas

Has your child ever fallen from a high place or down stairs....…...… No □ Yes □ _________________________
Has your child ever been in a motor vehicle accident or near miss…. No □ Yes □ _________________________
Has your child ever been seen on an emergency basis………...……. No □ Yes □ _________________________
Has your child ever broken any bones………………………………. No □ Yes □ _________________________
Has your child ever been hospitalized………………………….…. No □ Yes □ _________________________
Has your child had any surgeries……………………..……………. No □ Yes □ _________________________
Does your child spend time using a tablet, cell phone, computer or video games……. Never □ Rarely □ Daily □
Does your child watch TV……………………………………………………………….. Never □ Rarely □ Daily □
Does your child exercise…………………………………………………………………. Never □ Rarely □ Daily □
Does your child play contact sports……………………………………………………… Never □ Rarely □ Daily □
Does your child carry a backpack…………………………………………………………Never □ Rarely □ Daily □
Does your child's backpack weigh less than 15% of his/her body weight……. No □ Yes □
Does your child wear the backpack on both shoulders at the same time……… No □ Yes □ Sometimes □
Does your child show excessive or unusual shoe wear patterns………………. No □ Yes □
Does your child wear custom orthotics………………………………………... No □ Yes □

Chemical stressors

Have you chosen to vaccinate your child: No □ Yes, on a modified schedule □ Yes, on schedule □
Any of the following reactions to vaccinations? Fever □ Welt at injection site □ Rash □ Diarrhea □ Fatigue □
Seizures □ Developmental regression □ Other: ____
Does your child receive an annual flu shot: No □ Yes □
Has your child received antibiotics: No □ Yes □ If yes, how many doses in the past 6 months? ______________
Does your child take any daily medications: No □ Yes □ If yes, what medications and for what purpose
____
How many glasses of water a day does your child drink? _______
How many glasses of milk, juice, and/or soda does your child drink per day? _________
Does your child eat gluten (wheat products): No □ Yes □ Yes, trying to eliminate □
Does your child eat dairy: No □ Yes □ Yes, trying to eliminate □
Does your child eat refined sugars (white sugar), white breads, or pasta**:** No □ Yes □ Yes, trying to eliminate □
Does your child eat boxed frozen foods: No □ Yes □ Yes, trying to eliminate □
Does your child eat artificial sweeteners: No □ Yes □ Yes, trying to eliminate □
Does your child eat organic foods: No □ Yes □
Does your child have any dietary restrictions: No □ Yes □ If yes, explain: _____________________________
Is your child exposed to second hand smoke: No □ Yes □
Does your child take a probiotic daily: No □ Yes □
Does your child take vitamin D3 daily: No □ Yes □ If yes, daily IU:__________
Does your child take Omega 3 supplements daily: No □ Yes □ If yes, amount and type: __________________
Other supplements or homeopathics? ____

Patient's Name:______________________________ DOB: ______________ Date:_____________

NOTICE OF PRIVACY PRACTICES

I understand and have read and/or been provided with a copy, at my request, of the ***Notice of Privacy Practices*** brochure that provides a more complete description of information uses and disclosures.

The patient identified above authorizes Affinity Chiropractic to use and or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- ✓ I give permission to Affinity Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday/holiday cards, and information about treatment alternatives or other health related information.
- ✓ If Affinity Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine, voicemail, or with a person in my household.
- ✓ I give Affinity Chiropractic permission to treat me in an open room where other patients may overhear some of my protected health information during the course of care. Should I need to speak with the doctor, at any time, in private or prefer a closed treatment room, the doctor will be happy to provide a private room for these conversations and/or treatments.
- ✓ I authorize Affinity Chiropractic to discuss my treatment, schedule, or account information with:
  Spouse:__________________________ Family:__________________________
  Other:_____________________
- ✓ By signing this form, you are giving Affinity Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization will expire seven years after the date upon which it was signed.

This authorization is requested by Affinity Chiropractic for its own use/disclosure of PHI (protected health information). You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Affinity Chiropractic will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

ADDITIONAL DOCUMENTATION

I have been provided with a copy of the Financial and Office Policies for Affinity Chiropractic. I understand my obligations to comply with these policies and all questions regarding these policies have been answered to my complete satisfaction.

I have been provided with a copy of the Fee Schedule for Affinity Chiropractic.

____ _________________
Patient signature Date

____ _________________
Legal guardian signature-relationship to patient Date

Affinity Chiropractic 1900 Main St. Ste D, Klamath Falls, OR 97601 ph: 541-887-8555 fax: 541-887-8556

Fee Schedule-Cash/Medical Insurance Patients

Welcome to Affinity Chiropractic we are pleased to provide you with quality chiropractic care at the following rates:

Service	Fee
Initial examination & report of findings (no adjustment)	$90-180
Initial examination, report of findings, first adjustment	$135-240
Office visit – spinal adjustment only	$45
Office visit – extra-spinal adjustment	$15
Office visit - No adjustment	$45
Re- examination	$70-90
Self care / rehab instruction (in office-15 min)	$55
Cold laser	$20
Neuromuscular re-education	$40
Custom orthotic management	$40

Please ask about discounted pre-payment options and family wellness packages.

Financial and Office Policies

Financial Responsibilities

- Payment is due at time of service.
- Initial visit is paid in full at time of service.
- If you do not attend and do not cancel a scheduled appointment, you will be assessed a $25.00 "no show fee". This fee must be paid prior to any further appointments being scheduled.
- We bill insurance as a courtesy to our patients once insurance has been qualified. We will bill secondary insurance companies on a case by case basis based on the types of insurances involved. Patients are responsible for all deductibles and co-payments. You are responsible for any amount that is not paid by your insurance company.
- There is a $25.00 Charge for any returned checks.
- If an account has gone 90 days without a payment, the account will be sent to collections.
- If care is discontinued for any reason, account balance is to be paid in full.
- Payment plans are available and will be presented to you with your exam results.

Office Policies

- We know that your time is valuable, so we strive to see all patients at their scheduled time. In return, we expect you to be on time.
- If you should need to cancel an appointment please call the office 2 hours prior to scheduled time, this will allow another patient to be seen in that time slot.
- You may be terminated as a patient in our office if you choose to No Call/No Show more than 3 times in a month's period.
- Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to getting to know you and your family.

Affinity Chiropractic 1900 Main St. Ste D, Klamath Falls, OR 97601 ph: 541-887-8555 fax: 541-887-8556

Patient's Name:______________________________ DOB: _____________ Date:____________

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Signature:________________________________ Date:_______________

Witness Name:___________________________ Signature:_______________________________ Date:_________

Authorization For Care of Minor (sign only for care of a child)

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

I clearly understand and realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

____ ____________

Signature Date

____ ____________

Witness signature Date