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| chiro_logo.eps | Kim Miller Beard, DC  517-668-6215 phone  517-668-6385 fax  13105 Schavey Road  DeWitt, MI 48820  [www.balanceyourlifechiropractic.com](http://www.balanceyourlifechiropractic.com)  [info@balanceyourlifechiropractic.com](mailto:info@balanceyourlifechiropractic.com) |

Personal Information

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | | | | | | Last Name: | |  | | | | | | | Middle Initial: | | |  | |
| Presenting Parents Name: | | |  | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | |
| City/State/Zip: | | |  | | | | | | | | | | | | | | | | | |
| Home Phone: | | ( ) | | |  | | | | Work Phone | | | ( ) |  | | | | | | | |
| Mobile Phone: | | | ( ) | | |  | | | Email: |  | | | | | | | | | | |
| Social Security #: | | | |  | | | | | Birth Date: | |  | | | Age: |  | | Sex: | * M | | * F |
| How were you referred to Balance Your Life Chiropractic: | | | | | | | |  | | | | | | | | | | | | |

Emergency Information

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | Relation: | |  | |
| Home Phone | | | :( ) |  | Work Phone: | | ( ) | |  |
|  | |  | | | | | | | |

Birthing History

Place of birth: Home Birthing Center Hospital Other, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Birth: C-section Vaginal

Was ultrasound used during pregnancy? Yes No If yes, how many times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was labor induced? Yes No If yes, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was Anesthesia used? Yes No Type(s) of Anesthesia use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there any notable Doctor assisted birth trauma? Twisting or Pulling Vacuum Extraction Forceps Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any special medical procedures or tests performed? Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was the child breast fed? Yes No If yes, to what age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the child formula fed? Yes No If yes, at what age, and what brand of formula?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life.

Can you recall ANY jolts, falls, or traumas to this child? Yes No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has this child experienced any fractures or dislocations? Yes No

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other than the time spent sitting in a classroom, does your child spend prolonged time sitting? Yes No

Which activities does this child participate in?

Soccer Football Gymnastics Karate Hockey Basketball

Video Games Dance Wrestling Baseball Softball Cheerleading

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your child’s overall diet? Poor Somewhat Healthy Healthy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Chief Complaint

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What is your major complaint? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | |  | | |
| When did this symptom(s) begin? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Describe what happened/how it happened: | | |  | |
| What is the pain interfering with the most in your life? | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

Please mark any of the following conditions your child has experienced:

Colic Irregular Sleeping Patterns Nightmares Seizures Tantrums Ear Infections Allergies Asthma Headaches Poor Digestion Repeated Infections or Colds Bedwetting Learning Disorders Emotional Disorders ADD or ADHD

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all medications your child has been treated with since birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were you informed of any adverse reactions to any of the above-listed medications? Yes No

Office Policy

1. Records are the property of our office. Copies are only given with written permission and appropriate copying fees apply.
2. If you do not understand the procedures in your course of care, please ask. If you don’t ask, we assume you understand and consent to treatment.
3. Insurance policies are an arrangement between you and your insurance company, NOT between the insurance company and this office. You are ultimately responsible for any balance at this office.
4. Co-pays/deductibles are due at the time of service. Non-covered services are due upon billing.
5. We have a $25 No Call No Show fee (Medicaid is exempt from this).
6. Those without insurance are obligated to pay the full price of services at the time of service.
7. We accept MC/Visa/Discover.

I authorize the release of information necessary to process my health insurance claims. \_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Minor Policy

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the legal parent/guardian of the minor child named \_\_\_\_\_\_\_\_\_\_\_\_\_\_. I hereby grant my informed consent for my child to receive chiropractic treatment at Balance Your Life Chiropractic without my presence.

* **You authorize your child to receive care and attend appointments independently (16 years old and older).**
* **Scheduling an appointment can be done without parent/guardian present but missed appointments will fall under our No Call No Show fee policy.**
* **You consent to the billing of services rendered and if appointments are not paid at the time of service, a bill will be sent to the parent/guardian at the end of each month for appointments attended by your child.**
* **I have talked to my child about chiropractic care and understand that the child needs to notify or ask the doctor if they do not understand the procedures. If you do not ask, we assume you understand and consent to treatment.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize the listed people below to accompany my child to their appointments.

First & Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First & Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First & Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent for Purposes of Treatment Payment and Healthcare Operations**

I acknowledge that Balance Your Life Chiropractic’s “Notice of Privacy Practices” can be provided to me.

I understand I have the right to review Balance Your Life Chiropractic’s Notice of Privacy Practices prior to signing the document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of the health care operations at Balance Your Life Chiropractic. The main administration desk can provide the Notice of Privacy Practices upon request. This Notice of Privacy Practices also describes my rights and Balance Your Life Chiropractic’s duties with request to my protected health information.

Balance Your Life Chiropractic reserves the right to change the privacy practiced that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Balance Your Life Chiropractic’s website (if applicable).

I have the right to revoke this consent, in writing, except to the extent the Balance Your Life Chiropractic has acted in reliance of the consent.

**Patient Acknowledgement**

By subscribing my name below, I acknowledge receipt of the copy of this notice and understand and my agreement to its terms.

Signature of the Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of the Personal Representative’s Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_