Grace Chiropractic
315 S Church St Suite C
Hendersonville, NC 28792
(828) 435-2377

Patient History Form

Today's Date _____ Birthday _____ Sex ○Male ○Female
First Name _____ Middle Name _____ Last Name_____
Home # _____ Cell # _____ Height: _____ Weight: _____
Address _____ City, State Zip code _____
Emergency Contact and Relation _____ Emergency Phone _____
Number of siblings_____ Who referred you to us? _____
Reason for seeking chiropractic care**:** _____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_Runny Nose	_Diarrhea	_Broken bones
_ADHD	_Itchy Eyes	_Poor Appetite	_Sprains/Strains
_Backaches	_Rashes	_Hyperactivity	_Hernias
_Heart Condition	_Neuritis	_Behavioral	_Neck Pain
_Chronic Earaches	_Digestive trouble	_Insomnia	_Arm/Elbow Pain
_Diabetes	_Sinus Trouble	_Nightmares	_Leg/Hip Pain
_Tuberculosis	_Cough/Wheeze	_Bed Wetting	_Knee/Foot Pain
_Hypertension	_Chest Pain	_Pain Urinating	_Growing pains
_Fever/Chills	_Constipation	_Convulsions _Paralysis	_Joint Pain
_Frequent Colds	_Anemia	_Muscle Pain	_Scoliosis
_Headaches	_Rheumatic Fever	_Fainting	_Blood disorders
_Asthma	_Colic	_Stomach Aches	_Other: _____
_Allergies			

Health History:
Name of Pediatrician: _____ Date of last visit _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____

Prenatal History
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____
Complications during delivery: Y/N List: _____
Genetic disorders or disabilities: Y/N List: _____

Feeding history
Breast Fed: Y/N How long?_____ Formula fed: Y/N How long?_____
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping: Y/N

Childhood Diseases
O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___
O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Grace Chiropractic
315 S Church St Suite C
Hendersonville, NC 28792
(828) 435-2377

Family Health History:
Does anyone in your immediate family (parents, grandparents or siblings) have a history of cancer, diabetes, hypertension, strokes or other serious illnesses? If so, please list their relationship to you as well as the condition.

_____

_____

EHR Information:
Current Medications and Dosage: _____
Medication Allergies: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand and included information and certify it to be true to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and it's staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Grace Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:
The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

Missed Appointment Policy: Our policy is to charge **35.00** after **one** missed appointment not cancelled at least **24-hours in advance**. **Please help us to serve you better by keeping your regular scheduled appointment**.

Signature _____ Date _____
Printed Name _____

Grace Chiropractic
315 S Church St Suite C
Hendersonville, NC 28792
(828) 435-2377

Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather we care for the spine for the sole purpose of removing interference with and tension from the Nervous System. We also employ muscle work to improve muscle and joint stability and function. Every person is better with improved neural and musculo-skeletal function and this alone justifies our care. Our goal is to get your child's body working properly so your child can heal themselves. Research studies report improved health and wellness that is consistent with the care given. However, just what specific benefits your child will receive, no one can predict.

There are certain risks that have been reported to be associated with chiropractic care. Such risks include, but are not limited to fractures, dislocation, bruising, stroke, Horner's syndrome and other neurological complications. However, these incidents are extremely rare and the doctor will use his best judgment to try to avoid any negative events. I understand that the most common adverse reactions to care is temporary soreness. By my signature I give my consent for the Doctor of Chiropractic to examine my child's spine and/or extremities and/or muscle function. If I choose for my child to receive care, my payment for such services, and my bringing my child to each visit, in addition to my signature here, will serve as acknowledgment of my permission for the Doctor of Chiropractic to deliver such care to my child.

Privacy Notice

Your child's health information is private and protected by law. Your child's health information will only be used or disclosed for the purposed of giving care, billing, or supporting day-to-day operations in this office. You have a right to review your child's office file. You may restrict all or part of your child's health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

I have had a chance to ask questions about the privacy policy and I give my permission to this office to disclose my child's protected health information in accordance with such policies. I have read and understood the informed consent and give my permission for the Doctor of Chiropractic to deliver care to my child.

_____
Child's Name

_____
Parent Name Parent Signature Date

_____
Witness Signature Date