PRECISION
CHIROPRACTIC AND WELLNESS

PEDIATRIC – NEW PATIENT INTAKE

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Complete ALL Sections below. Highlighted Areas MUST be completed; if anything does not apply to you, put "N/A."

PATIENT INFORMATION

First Name: _____ **Middle Name:** _____ **Last Name:** _____

DOB: _____ / _____ / _____ **Age:** _____ years | months | weeks | days **SSN:** _ _ _ _ _ _ _ _ _

Sex: MALE / FEMALE **Height or Length:** _____ ft. _____ in. **Weight:** _____ lbs. _____ oz.

Primary Language: _____ **Ethnicity:** _____ **Number of Siblings:** _____

Mother's Full Name: _____ **Last 4-Digits of SSN:** _ _ _ _

DOB: _____ / _____ / _____ **Age:** _____ y.o. **Primary Language:** _____

Ethnicity: _____ **Marital Status:** _____ **Profession:** _____

Home Phone: (_ _ _) - _ _ _ - _ _ _ _ **Cell Phone:** (_ _ _) - _ _ _ - _ _ _ _ **Work Phone:** (_ _ _) - _ _ _ - _ _ _ _

Email: _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Father's Full Name: _____ **Last 4-Digits of SSN:** _ _ _ _

DOB: _____ / _____ / _____ **Age:** _____ y.o. **Primary Language:** _____

Ethnicity: _____ **Marital Status:** _____ **Profession:** _____

Home Phone: (_ _ _) - _ _ _ - _ _ _ _ **Cell Phone:** (_ _ _) - _ _ _ - _ _ _ _ **Work Phone:** (_ _ _) - _ _ _ - _ _ _ _

Email: _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Whose Phone Number would you like to receive Appointment Reminders? ☐ Mother's Cell Phone ☐ Father's Cell Phone

How did you hear about PCW? _____

Do we have your permission to use your first name to thank who referred you? ☐YES ☐NO

GUARDIAN INFORMATION – If Not Parent

Guardians Full Name: _____

DOB: _____ / _____ / _____ **Age:** _____ **y.o.** **Relationship:** _____

Home Phone: (_ _ _) - _ _ _ - _ _ _ _ **Cell Phone:** (_ _ _) - _ _ _ - _ _ _ _ **Cell Provider:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____

REASON FOR VISIT

Has your child previously had chiropractic care? ☐ NO ☐ YES**; please explain <u>why</u>, <u>when</u> and <u>who</u> was the doctor below:**

_____

_____

What is the Reason for your child's visit today? ☐ 1st Wellness Baby Check-Up ☐ Preventative Child Evaluation ☐ Injury or Specific Condition ☐ Other: _____

X-RAY RELEASE

I understand that standard x-ray procedure for a Pediatric Patient age 6 and under is to not perform x-ray analysis until at least age 7. But if certain circumstances occur such as but not limited to severe trauma, injury, car accidents, and lack of progress in care over extended time (after further consultation with other doctors), the attending doctor of Precision Chiropractic & Wellness will advise the guardian of the patient to allow the facility to take x-ray examination.

I understand that specific postural x-rays may be necessary for the identification of the location, presentation, and severity of Vertebral Subluxation. X-Rays may also be utilized to show progress after a period of recommended chiropractic care. Therefore, I authorize Precision Chiropractic & Wellness, or a certified employee has my permission to perform an X-ray evaluation.

Signature: _____ **Date:** _____ / _____ / _____

Female Patient: Has your child begun to have Menstrual Cycles? ☐YES ☐NO

☐ To the best of our knowledge, they are not pregnant, and we have been informed that x-ray can be hazardous to an unborn child.

Are they currently having a menstrual cycle? ☐YES ☐NO **If YES, Start Date:** _____ / _____ / _____

If NO, Date of Last Cycle Ended: _____ / _____ / _____

CONSENT TO CARE FOR MINOR

I certify that I am the parent or legal guardian of the minor listed above. I authorize the doctor(s) of Precision Chiropractic & Wellness to administer evaluation and care, and whomever they may designate as an assistant to administer evaluation, to my son/daughter.

Signature: _____ **Date:** _____ / _____ / _____

If your child has a specific **<u>Injury or Condition</u>** that you would like to have evaluated, please describe the injury/condition below on **Pages 3 - 5**.

If this is their **<u>1st Wellness Baby Check-Up</u>** or **<u>Preventative Child Evaluation</u>**, please go to **Pages 6**.

PRIMARY COMPLAINT – Please describe ONLY their Main Complaint Below

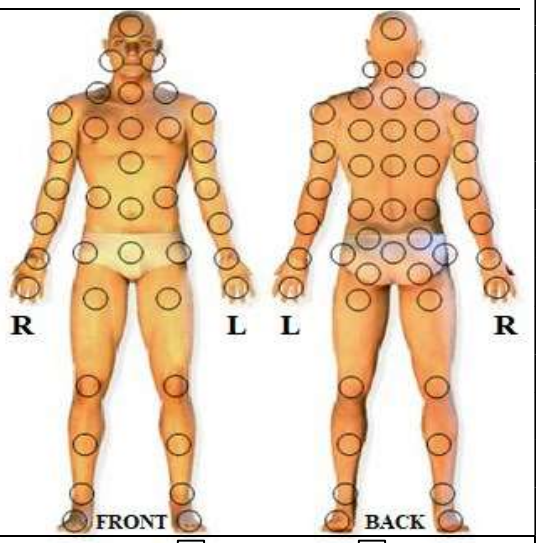
Is this Complaint a result of: ☐Auto-Accident ☐Injury Trauma ☐Sports Injury ☐Other: _____

Describe their Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where their Complaint is located →

Ex. Neck Pain → 



Please check the box(es) that best describe your discomfort:

☐Achy	☐Burning	☐Boring	☐Cramping	☐Deep	☐Dull
☐Numb	☐Pressure	☐Radiating	☐Random	☐Restricted	☐Sharp
☐Stiff	☐Superficial	☐Throbbing	☐Tight	☐Tingling	☐Weak

Does it travel, radiate, and/or extend anywhere? ☐YES ☐NO

If YES, where to? _____

How LONG have they experienced it? ____days ____weeks ____months ____ years

Have they EVER had this Complaint before? ☐YES ☐NO

How OFTEN do they feel this Complaint? ☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

How LONG does this Complaint last when felt? ☐ 0 – 10% ☐ 15 – 25% ☐ 30 – 50% ☐ 55 – 75% ☐ 80 – 100%

Rate their Intensity at its WORST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate their Intensity at its LOWEST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the Complaint Changing at all? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Is the Complaint worse: ☐ In the Morning ☐ During the Day ☐ At Night ☐ Same All Day

Explain what you have seen make it WORSE: _____

_____

Explain what you have seen make it BETTER: _____

_____

Rate if the Complaint Stresses your Child: ☐ No Stress ☐ Mild Stress ☐ Moderate Stress ☐ Significant Stress

How is your Complaint affecting their Life/Activities?

☐ Home Duties (ex. Chores) ☐ Self-Care (ex. Bathing)
☐ Relationships (ex. Family) ☐ Need Assistance
☐ Totally Impaired / Disabled ☐ No Effect

Is the Complaint Affecting their Student / Sport Status?

**If your child is not a Student, but Attends Day Care &/or Preschool, please use the "School" Options to Answer.

☐ No Effect ☐ School, Full Attendance
☐ Sports, Full Activity ☐ School, Partial Attendance
☐ Sports, Restricted Activity ☐ School Work & Test Affected

Have you had help for this before us? ☐Chiropractic ☐Medication ☐Physical Therapy ☐Surgery ☐Other: _____

Name of Doctor or Clinic: _____ **Date of Last Treatment:** _____ / _____ / _____

SECOND COMPLAINT – Please describe ONLY their 2nd Complaint Below

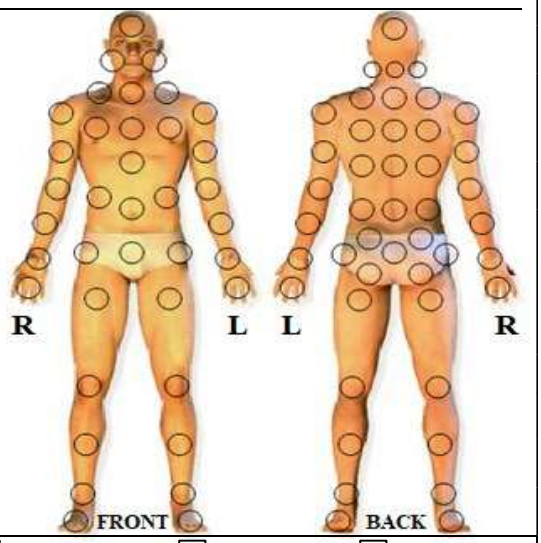
Is this Complaint a result of: ☐Auto-Accident ☐Injury Trauma ☐Sports Injury ☐Other: _____

Describe their Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where their Complaint is located →

Ex. Neck Pain → 



Please check the box(es) that best describe your discomfort:

☐Achy	☐Burning	☐Boring	☐Cramping	☐Deep	☐Dull
☐Numb	☐Pressure	☐Radiating	☐Random	☐Restricted	☐Sharp
☐Stiff	☐Superficial	☐Throbbing	☐Tight	☐Tingling	☐Weak

Does it travel, radiate, and/or extend anywhere? ☐YES ☐NO

If YES, where to? _____

How LONG have they experienced it? ____days ____weeks ____months ____ years

Have they EVER had this Complaint before? ☐YES ☐NO

How OFTEN do they feel this Complaint? ☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

How LONG does this Complaint last when felt? ☐ 0 – 10% ☐ 15 – 25% ☐ 30 – 50% ☐ 55 – 75% ☐ 80 – 100%

Rate their Intensity at its WORST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate their Intensity at its LOWEST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the Complaint Changing at all? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Is the Complaint worse: ☐ In the Morning ☐ During the Day ☐ At Night ☐ Same All Day

Explain what you have seen make it WORSE: _____

_____

Explain what you have seen make it BETTER: _____

_____

Rate if the Complaint Stresses your Child: ☐ No Stress ☐ Mild Stress ☐ Moderate Stress ☐ Significant Stress

How is your Complaint affecting their Life/Activities?

☐ Home Duties (ex. Chores) ☐ Self-Care (ex. Bathing)
☐ Relationships (ex. Family) ☐ Need Assistance
☐ Totally Impaired / Disabled ☐ No Effect

Is the Complaint Affecting their Student / Sport Status?

**If your child is not a Student, but Attends Day Care &/or Preschool, please use the "School" Options to Answer.

☐ No Effect ☐ School, Full Attendance
☐ Sports, Full Activity ☐ School, Partial Attendance
☐ Sports, Restricted Activity ☐ School Work & Test Affected

Have you had help for this before us? ☐Chiropractic ☐Medication ☐Physical Therapy ☐Surgery ☐Other: _____

Name of Doctor or Clinic: _____ **Date of Last Treatment:** _____ / _____ / _____

THIRD COMPLAINT – Please describe ONLY their 3rd Complaint Below

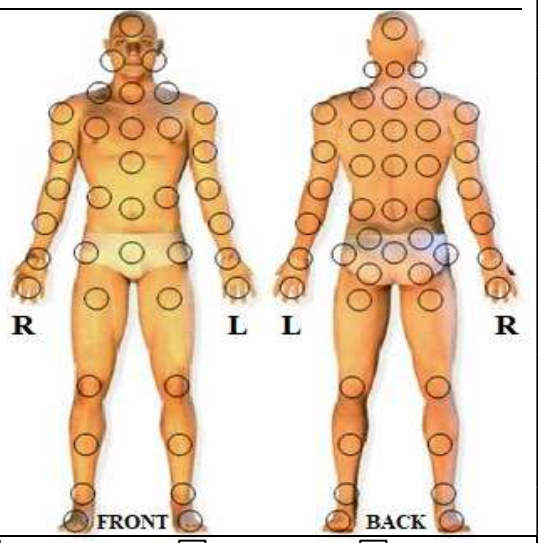
Is this Complaint a result of: ☐Auto-Accident ☐Injury Trauma ☐Sports Injury ☐Other: _____

Describe their Primary Complaint: _____

How did it Begin? _____

Fill-In the Circle(s), for where their Complaint is located →

Ex. Neck Pain → 



Please check the box(es) that best describe your discomfort:

☐Achy	☐Burning	☐Boring	☐Cramping	☐Deep	☐Dull
☐Numb	☐Pressure	☐Radiating	☐Random	☐Restricted	☐Sharp
☐Stiff	☐Superficial	☐Throbbing	☐Tight	☐Tingling	☐Weak

Does it travel, radiate, and/or extend anywhere? ☐YES ☐NO

If YES, where to? _____

How LONG have they experienced it? ____days ____weeks ____months ____ years

Have they EVER had this Complaint before? ☐YES ☐NO

How OFTEN do they feel this Complaint? ☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

How LONG does this Complaint last when felt? ☐ 0 – 10% ☐ 15 – 25% ☐ 30 – 50% ☐ 55 – 75% ☐ 80 – 100%

Rate their Intensity at its WORST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate their Intensity at its LOWEST level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the Complaint Changing at all? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Is the Complaint worse: ☐ In the Morning ☐ During the Day ☐ At Night ☐ Same All Day

Explain what you have seen make it WORSE: _____

_____

Explain what you have seen make it BETTER: _____

_____

Rate if the Complaint Stresses your Child: ☐ No Stress ☐ Mild Stress ☐ Moderate Stress ☐ Significant Stress

How is your Complaint affecting their Life/Activities?

☐ Home Duties (ex. Chores) ☐ Self-Care (ex. Bathing)
☐ Relationships (ex. Family) ☐ Need Assistance
☐ Totally Impaired / Disabled ☐ No Effect

Is the Complaint Affecting their Student / Sport Status?

**If your child is not a Student, but Attends Day Care &/or Preschool, please use the "School" Options to Answer.

☐ No Effect ☐ School, Full Attendance
☐ Sports, Full Activity ☐ School, Partial Attendance
☐ Sports, Restricted Activity ☐ School Work & Tests Affected

Have you had help for this before us? ☐Chiropractic ☐Medication ☐Physical Therapy ☐Surgery ☐Other: _____

Name of Doctor or Clinic: _____ **Date of Last Treatment:** _____ / _____ / _____

Do you have any Additional Complaints to Report that you would like our help with? ☐YES, I have more. ☐NO, not currently.

BIRTH HISTORY

3rd Trimester Presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Headfirst

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Type of Birth: ☐ Normal Vaginal ☐ Planned Caesarian Section ☐ Vacuum
☐ Induced Vaginal ☐ Emergency Caesarian Section ☐ Suction Cap
☐ Epidural Vaginal ☐ Forceps ☐ Water

Problems during Labor / Delivery: ☐ Antibiotics ☐ Excessive Bleeding ☐ Failure to Thrive ☐ Meconium
☐ Fetal Distress ☐ Perinatal Asphyxia ☐ Uterine Rupture ☐ Malposition
☐ Other(s): _____

Was the baby born with any <u>Genetic Disorders</u> &/or <u>Disabilities</u>? _____
_____
_____

Was the baby born with any <u>Congenital Anomalies</u> &/or <u>Defects?</u> _____
_____
_____

Birth Weight: _____ ounces **Birth Length:** _____ inches

AGAR Scores: _____ at Birth _____ at time of Existing Birth Center or Hospital

Was the Child's Skin Color EITHER of the following at birth? ☐ Jaundice (Yellowing) ☐ Cyanosis (Blue Color)

GROWTH & DEVELOPMENT

Child Dietary Habits: ☐ Breast Feeding ☐ Bottle – Pumped Breast Milk
☐ Bottle – Store Bought Formula ☐ Bottle – Prescribed Formula
☐ Bottle – Homemade Formula ☐ Solid Foods – Store Bought
☐ Solid Foods – Homemade ☐ Solid Foods – Fast Food
☐ Other(s): _____

Number of Hours SLEEPING at NIGHT on average? _____

How would you describe their Quality of Sleep? ☐ Good ☐ Fair ☐ Poor

How many NAPS do they take in a day? _____

At what AGE did your Child begin doing the following:
____ Respond to Sound ____ Follow an Object with their Eyes
____ Sit Alone/Unsupported ____ Crawl
____ Hold Head Up ____ Stand Upright
____ Tummy Time ____ Walk Alone/Unsupported

PATIENT HEALTH HISTORY

Primary Care Physician Full Name: _____

Clinic Name: _____ **Clinic Phone: (_ _ _) - _ _ _ - _ _ _ _**

Clinic Address (City, State, Zip): _____

Please List ALL Medications, including their Name, Dosage & Reason your Child has been Prescribed them. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your doctor.

1._____ **Dosage:**_____ **Reason:**_____

2._____ **Dosage:**_____ **Reason:**_____

3._____ **Dosage:**_____ **Reason:**_____

4._____ **Dosage:**_____ **Reason:**_____

5._____ **Dosage:**_____ **Reason:**_____

Please List ALL Nutrients & Supplements, including their Name, Amount & Reason are taking them. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1._____ **Amount:**_____ **Reason:**_____

2._____ **Amount:**_____ **Reason:**_____

3._____ **Amount:**_____ **Reason:**_____

4._____ **Amount:**_____ **Reason:**_____

5._____ **Amount:**_____ **Reason:**_____

Past Surgeries (Reason, Procedure & Date): _____

_____

_____

_____

Auto Accident(s)? ☐YES ☐NO Hospitalized? ☐YES ☐NO Date(s): _____

Broken Bone(s)? ☐YES ☐NO Hospitalized? ☐YES ☐NO Date(s): _____

Sprains &/or Strains(s)? ☐YES ☐NO Hospitalized? ☐YES ☐NO Date(s): _____

Stroke(s)? ☐YES ☐NO Hospitalized? ☐YES ☐NO Date(s): _____

Have you vaccinated your child? ☐ NO ☐ YES, As Scheduled with Pediatrician ☐ YES, Delayed Schedule

Has your child ever had an adverse reaction to a vaccine? ☐ NO ☐ YES, please describe: _____

_____

Number of Antibiotic Treatments Given? Within Last 6 Months _____ Within his/her Lifetime: _____

Has your Child ever been treated on an Emergency Basis? If Yes, Please Explain: _____

_____

_____

_____

PATIENT HEALTH HISTORY - CONTINUED

At what Age, if ever, did your child suffer from any of the following Childhood Diseases?

_____ Chickenpox _____ Mumps _____ Measles _____ Rubella

_____ Rubeola _____ Whooping Cough _____ Other: _____ _____ Other: _____

Has your Child ever suffered from any of the following spinal and/or extremity traumas?

☐ Fall(s) while learning to Walk – Multiple ☐ Fall(s) from Bed, Crib or Couch ☐ Fall(s) from Highchair ☐ Fall(s) from Baby Walker

☐ Fall(s) from Baby Swing ☐ Fall(s) from Changing Table ☐ Fall(s) Downstairs ☐ Fall(s) off Bicycle

☐ Fall(s) off Skateboard or Skates ☐ Fall(s) off Swing ☐ Fall(s) off Playground ☐ Fall(s) off Slide

Please list any other Traumas your child has experienced in their life: (auto accidents, major falls, birth traumas, etc.)

1._____ Date: _____ / _____ / _____

2._____ Date: _____ / _____ / _____

3._____ Date: _____ / _____ / _____

4._____ Date: _____ / _____ / _____

5._____ Date: _____ / _____ / _____

Please check off ALL symptoms, injuries, conditions, and/or diagnosis below, that your Child has suffered in the past 6 months to year:

☐ADD/ADHD	☐Delayed Speech	☐Hernias / Ruptures	☐Stomach Aches
☐Allergies	☐Depression	☐Hyperactivity	☐Temper Tantrums
☐Anxiety	☐Diabetes	☐Jaw/TMJ Problems	☐Walking or Crawling Problems
☐Asthma	☐Diarrhea	☐Paralysis	☐Other: _____
☐Attention Issues	☐Dizziness	☐Poor Appetite	☐Other: _____
☐Autism	☐Earaches	☐Rashes	☐Other: _____
☐Bed Wetting	☐Emotional Stress	☐Runny Nose	☐Other: _____
☐Behavioral Problems	☐Fainting	☐Scoliosis	☐Other: _____
☐Chronic Colds/Flus	☐Growing Pains	☐Seizures/Convulsions	☐Other: _____
☐Colic	☐Headaches	☐Sinus Trouble	☐Other: _____
☐Constipation	☐Heart Trouble	☐Sports / Head Injuries	☐Other: _____

CHILD HABITS

Does your child play Sports? (Sport, Position & How Long?) _____

_____

_____

_____

Do they favor a side with their Backpack? ☐Favor Right Side ☐Favor Left Side ☐Seem to Switch Sides ☐Wear Both Straps

How many hours a DAY do they spend on a Cell Phone, Tablet &/and gaming device? ☐1 – 2 Hours ☐ 3+ Hours ☐None

How many hours a WEEK do they use a TV, Video Games, Computers, etc.? ☐1 – 2 Hours ☐3+ Hours ☐None

In what Position do they normally Sleep and/or Nap in? ☐Belly/Stomach ☐Right Side ☐Left Side ☐Curled Up ☐ Back

FAMILY HEALTH HISTORY

Please review the listed health issues/conditions below and **Place "X"** in the Appropriate Column that applies for **"C"** – CHILD, **"GM"** – Grandmother, **"GF"** – Grandfather, **"M"** – Mother, **"F"** – Father, **"B"** – Brother, and **"S"** – Sister.

CONDITION	C	GM	GF	M	F	B	S	CONDITION	C	GM	GF	M	F	B	S
Alcoholism	☐	☐	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	Hypertension	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	HYPERthyroidism	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	HYPOthyroidism	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	Lupus	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	MS	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	Obesity	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	Other Cancer	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	Rheumatoid Arth.	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	Seizures	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐	Shingles	☐	☐	☐	☐	☐	☐	☐
GERD	☐	☐	☐	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Your Child's lifestyle, diet and exercise habits play an extremely important role in your overall health and risk of chronic disease. The following questions are designed to help us understand your habits, desires as well as commitments to make changes to those habits if necessary.

How OFTEN are they Physical Active ☐Daily ☐Weekly ☐Never **Hours Per Week?** _____

How much water do they drink a day? _____, 8-oz. glasses **What kind?** ☐Bottled ☐Distilled ☐Filtered ☐Tap

How many times do they eat Fast Food each week? _____ **How often do they have Soda?** ☐Daily ☐Weekly ☐Never

How often do they have Caffeine? ☐Daily ☐Weekly ☐Never **How often do they have Tea?** ☐Daily ☐Weekly ☐Never

What age di they start to have Dairy Products? _____ **y.o.** **How much Dairy Weekly?** _____

How often do you take Over-Counter Medication? ☐Daily ☐Weekly ☐Never **What do you take?** _____

How many servings of fruits & vegetables does your child eat in a Day? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

1 Medium Fruit = 1 Serving 1 Cup of Raw Vegetables = 1 Serving ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15

How often do they pass a Bowel Movement? ☐1 a Day ☐2 a Day ☐3+ a Day ☐Every other Day ☐1 or more Weekly

HEALTH CHECKLIST – REVIEW OF SYMPTOMS & SYSTEMS

Please review the listed below of Symptoms or Health Conditions. Please **Check or "X"** under **Current** if THEY currently are experiencing the symptom / condition or under **Past** if THEY have EVER experienced it in before no matter how long ago.

Current	Past	Symptom / Condition	Current	Past	Symptom / Condition
☐	☐	Fevers &/or Chills	☐	☐	Dry Cough
☐	☐	Trouble Getting to Sleep	☐	☐	Productive Cough
☐	☐	Trouble Staying Asleep	☐	☐	Wet Cough
☐	☐	Fatigue	☐	☐	Coughing Up Blood
☐	☐	Weakness / Lack of Strength	☐	☐	Shortness of Breath
☐	☐	Low Energy	☐	☐	Fast Breathing
☐	☐	Unexplained Weight Loss	☐	☐	Painful Breathing
☐	☐	Unexplained Weight Gain	☐	☐	Chest Pain
☐	☐	Skin Rashes (such as Eczema)	☐	☐	High Blood Pressure
☐	☐	Skin Dryness	☐	☐	Low Blood Pressure
☐	☐	Skin Color Changes	☐	☐	Orthostatic Hypotension
☐	☐	Sores &/or Ulcers	☐	☐	Difficulty Breathing Lying Down
☐	☐	Hair & Nail Changes	☐	☐	Palpitations ("Heart Skipping a Beat")
☐	☐	Headaches	☐	☐	Awake from Sleep with Shortness of Breath
☐	☐	Migraines	☐	☐	Constipation
☐	☐	Head Injury	☐	☐	Diarrhea
☐	☐	Struck Unconscious	☐	☐	Change in Bowel Habits
☐	☐	Earache(s)	☐	☐	Vomiting
☐	☐	Hearing Loss &/or Difficulty Hearing	☐	☐	Change in Appetite
☐	☐	Ear Drainage	☐	☐	Heartburn, With Acidic Foods
☐	☐	Ringing in the Ears (Tinnitus)	☐	☐	Heartburn, With Fatty Foods
☐	☐	Eye Pain &/or Pressure	☐	☐	Heartburn, In-Between Meals
☐	☐	Blurry Vision	☐	☐	Heartburn, 30 minutes to 1 hour after Eating
☐	☐	Double Vision	☐	☐	Heartburn, When Lying Down
☐	☐	Cataracts	☐	☐	Rectal Bleeding / Blood When Whipping
☐	☐	Glaucoma	☐	☐	Sudden Urgency to Urinate
☐	☐	Redness of the Eyes	☐	☐	Loss of Bladder Control
☐	☐	Vision Loss	☐	☐	Frequent Urination
☐	☐	Seasonal Allergies	☐	☐	Blood in Urine
☐	☐	Sinus Infection(s)	☐	☐	Kidney Stone(s)
☐	☐	Sinus Pressure &/or Pain	☐	☐	Bladder Infection(s)
☐	☐	Hay Fever	☐	☐	Candida or other Fungal Infection(s)
☐	☐	Discharge from Nose	☐	☐	Genital Sores – Male & Female
☐	☐	Loss of Smell	☐	☐	STD's – Male & Female
☐	☐	Thrush – Oral Fungal Infection(s)	☐	☐	Pain with Sex – Male & Female
☐	☐	Difficulty Swallowing	☐	☐	Testicle Pain – Male Only
☐	☐	Loss of Taste	☐	☐	Testicle Masses or Lumps – Male Only
☐	☐	Swollen Tongue	☐	☐	Erectile Dysfunction – Male Only
☐	☐	Dry Mouth	☐	☐	Genital Discharge – Male & Female
☐	☐	Breast Lumps – Male & Female	☐	☐	Leg Cramps, During Day
☐	☐	Breast Pain – Male & Female	☐	☐	Leg Cramps, Wake You At Night
☐	☐	Nipple Discharge – Male & Female	☐	☐	Calf Pain with Walking
☐	☐	Breast Cancer – Male & Female	☐	☐	Calf Pain with Stairs
☐	☐	Mastectomy – Male & Female	☐	☐	Swelling in Calves
☐	☐	Breast Feeding Currently – Female Only	☐	☐	Swelling in Ankles
☐	☐	Breast Feeding Difficulties – Female Only	☐	☐	Swelling in Feet

HEALTH CHECKLIST – CONTINUED

Current	Past	Symptom / Condition	Current	Past	Symptom / Condition
☐	☐	Neck Pain	☐	☐	Sweat Easily
☐	☐	Jaw Pain (TMJ)	☐	☐	Strong Thirst
☐	☐	Shoulder Pain	☐	☐	Cold Intolerance
☐	☐	Arm Pain	☐	☐	Heat Intolerance
☐	☐	Wrist-Hand Pain	☐	☐	Hair Loss
☐	☐	Mid-Back Pain	☐	☐	Cold Hands & Feet
☐	☐	Low-Back Pain	☐	☐	PMS – Female Only
☐	☐	Hip-Thigh Pain	☐	☐	Menopause – Female Only
☐	☐	Knee-Leg Pain	☐	☐	Endometriosis – Female Only
☐	☐	Ankle-Foot Pain	☐	☐	Ovarian Cysts – Female Only
☐	☐	Joint Stiffness	☐	☐	Prostate Problems – Male Only
☐	☐	Joint Swelling	☐	☐	Infertility or Sterility – Male & Female
☐	☐	Redness of Joints	☐	☐	Heavy Menstrual Cycles
☐	☐	Arthritis	☐	☐	Irregular Menstrual Cycles
☐	☐	Sport Injury(s)	☐	☐	Heavy Cramping &/or Pain with Cycles
☐	☐	Fracture(s)	☐	☐	Hot Flashes
☐	☐	Anemia	☐		**Food Allergies / Sensitivities – List Below:**
☐	☐	Bruise Easily			_____
☐	☐	Bleed Easily, Does not Stop Quickly			_____
☐	☐	Slow to Heal after cuts or skin wounds			_____
☐	☐	Confusion &/or Memory Loss			_____
☐	☐	Dizziness	☐		**Medication Allergies – List Below:**
☐	☐	Uncontrolled Falling			_____
☐	☐	Fainting / Passing Out			_____
☐	☐	Difficulty Speaking			_____
☐	☐	Seizures &/or Convulsion			_____
☐	☐	Spinning &/or Vertigo			
☐	☐	Tremors	☐		**Other Allergens – List Below:**
☐	☐	Incoordination			_____
☐	☐	Paralysis			_____
☐	☐	Neuropathy			_____
☐	☐	Anxiety &/or Depression			_____

STRESS ASSESSMENT

Physical	☐ Birth Traumas (Mother & / or Child)	☐ Sitting on Wallet in Back Pocket for Years
	☐ Sleeping on Stomach	☐ Extensive Computer, Game System or TV Use
	☐ Repetitive Bending & Lifting	☐ Carrying Heavy Purse / Backpack / Child
	☐ Minimal / No Exercise	☐ Continuous Hours of Sitting / Standing
	☐ Poor Posture	☐ Extensive Cell Phone or Tablet Use
Chemical	☐ Chemical Exposure (At Work or Near Home)	☐ Live Near Chemical or Energy Facilities
	☐ Second-Hand Smoke Exposure	☐ Mold Exposure
	☐ Poor Diet	☐ Excessive Sugar / Artificial Sweeteners Use
	☐ Excessive Caffeine	☐ Excessive Salt Usage
	☐ Prescription Medication Use	☐ Over-the-Counter Drug Use (ex. Ibuprofen)
Emotional	☐ Difficulties with Relationships	☐ School Difficulties
	☐ Difficulties with Other Children	☐ Suppressed Feelings
	☐ Sick Loved One(s)	☐ Loss of Love One(s)

Which do you feel is their primary stress? ☐Physical ☐Chemical ☐Emotional

Please Explain Why: _____

FINANCIAL RESPONSIBILITY **INITIALS: _____**

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of my insurance plan and/or benefits. ***I understand that Precision Chiropractic & Wellness is a Point-Of-Service Office;*** I understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment up front at the time of service. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. ***I am responsible for submitting any insurance claim to my insurance to request reimbursement from an out-of-network provider.*** PCW will assist the process by preparing any necessary reports and forms required for me to collect from the insurance company.

I hereby authorize the Precision Chiropractic & Wellness 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.

APPOINTMENT POLICIES **INITIALS: _____**

Appointment Changes: A **24 hr. advanced notice** is required for all appointment changes including but not limited to ***Cancellations, Rescheduling's, and/or Changing Appointments***. The 24-hr. notice gives us an opportunity to serve another member of our community with care.

Late Changes that are less than 24-hr. advanced notice, will be subject to a ***$15.00 fee*** for a visit that consists of an Adjustment and/or ***$30.00 fee*** for a visit that includes any examination (i.e., new patient examination, progress examination and/or x-ray analysis). All fees must be paid before receiving or scheduling another service.

We understand unexpected circumstances happen and may waive the fee on a case-by-case basis. Medical and family emergencies will never result in fees when brought to PCW's attention. Workplace and other unforeseen schedule conflicts must be brought to PCW's attention to be considered for a fee waiver.

Missed Appointments: Missed Appointments that were not cancelled, changed, or rescheduled with Precision Chiropractic & Wellness **24-hrs. prior** to the scheduled time, i.e., a **"No-Call, No-Show"** will result in an automatic ***full appointment charge fee*** of services that were scheduled to be provided on that appointment time & date.

We understand that unexpected circumstances occur and waiving of fees will be assessed on a case-by-case basis and only considered ***if the patient calls the same business day*** within PCW's business hours (found at **www.pcwchiro.com**). After business hour calls do not apply. This fee must be paid before receiving or scheduling another service and if said balance is not settle, PCW reserves the right to refuse to provide services and/or care.

PAYMENT POLICIES **INITIALS: _____**

Card Payments: PCW accepts most major Debit & Credit Cards with an additional ***transaction fee of 2.8%*** for processing.

Declined Payments: If payment is declined (card exp., returned/declined checks, etc.) there is a ***$20.00 fee***.

Late Payments: Payments that are ***14 days past due are considered late*** unless other arrangements have been made between you and Precision Chiropractic & Wellness.

Over-Due Balances: ***15% of total due balance*** is added ***every 30 days*** past due. If your account has an outstanding balance, no future appointments will be scheduled until said balance has been paid in full.

Collections: Balances not paid after ***12 Late Periods (360 Days)*** will be sent to Collections to be settled.

AUTO-DRAFT AUTHORIZATION **INITIALS: _____**

☐ **YES, I AGREE:** By ***checking Yes and signing below***, I am authorizing Dr. Joshua Holda, D.C. and Precision Chiropractic & Wellness located at either address below to automatically draft payments from my **card on file** following any accumulation of charges or fees defined under ***Financial Responsibility, Appointment Policies, Payment Policies and Office Procedures*** found above. I understand that I will only be charged if I violate any of these terms and no additional charges will be filed without my notification.

☐ **NO, I DECLINE:** By ***Checking No and signing below***, I understand that I am denying my ability to place a card on file for the use of settling any accumulation of charges or fees defined under ***Financial Responsibility, Appointment Policies, Payment Policies and Office Procedures*** found above. I understand that I will be subjected to the ***Over-Due Balance*** fees and ***Collections*** policy if I do not settle my balance with PCW.

OFFICE PROCEDURES **INITIALS: _____**

Video Recording: I authorize the Doctor of Chiropractic and anyone working in the Precision Chiropractic & Wellness office authorized by the Chiropractor, permission to record my visit or gait pattern **upon request** for the use of analysis and my care.

No Cell Phones or Other Recording Devices: Patients are not allowed recording devices within this clinic with the sole exception of the waiting room area (this exception does not include changing, examination or treatment rooms).

X-Ray Imaging Copies: At your request, you can receive a copy of your x-rays to a disc for a fee of ***$10.00*** per x-ray series that is requested. A **Record Release** request form must be on file before these can be released to the patient or pre-approved third-party.

Nutritional Supplementation/Counseling: I understand that the purpose of a nutritional protocol is to provide special food concentrates for dietary purposes. I understand that these protocols are not intended to diagnose or cure any disease. PCW's policy is that nutritional supplements are not refundable or exchangeable due to the maintenance of quality control of our inventory.

Testimonial Consent: PCW celebrates and displays chiropractic testimonials in our office, our website and on our social media outlets to educate others about the benefits of chiropractic care. Please CHECK if you wish to allow us to share your success. ☐**Yes, I DO** ☐**No, I DO NOT**

PATIENT CONSENT

INITIALS: _____

For use and/or disclosure of protected health information to carry out Analysis, treatment, payment, and healthcare operations:

1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
   - Postcards and other material mailed to the addresses I have provided.
   - Telephoning me at the numbers I have provided and leaving messages on the answer machines or with the individual answering the phone.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.
6. I understand that this consent is valid while I am a patient on file in this office and written consent need only be obtained once. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already acted in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.
7. By Initialing Above and Signing Below, I authorize Precision Chiropractic & Wellness and it's employees to utilize ALL of my health records on file to be utilized at the discretion of PCW for activities such as but not limited to office education, marketing, student education, and seminar education. Checking here, I also give PCW the ability to record my visits upon verbal agreement to be recorded, to utilize said recordings and my health records to consult with other healthcare professionals when necessary for my case.
8. I give Precision Chiropractic & Wellness permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.
9. The doctor recommends that my spouse be present at my report of findings visit; therefore, I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

TERMS OF ACCEPTANCE

INITIALS: _____

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease or conditions. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you and when recommend any necessary referral to the appropriate health care provider. Regardless of what the disease or conditions is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints, and organ systems the nerve supplies.

Chiropractic—like any other therapeutic programs in healthcare is not without its risks. Chiropractic adjustments can result in adverse effects such as discomfort, pain, and soreness. In rare cases with underlying physical defects, deformities or pathologies may be at risk or prone to injury. It is the responsibility of the patient to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Chiropractor. The Doctor of Chiropractic will not give any treatment or care if he or she is aware that such care should not be provided for a particular condition or circumstance.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic Care on this basis.

SIGNATURE

By signing below, I acknowledge that I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection as well as use of this information to this office of Precision Chiropractic & Wellness and agree to all terms above. I understand that I have the right to refuse to sign this authorization, and if I choose to, this practice has the right to refuse to give care and will not treat me. I agree that a photocopy of this form is to be considered as valid as the original and is valid indefinitely as a patient on record with Precision Chiropractic & Wellness or until further notified of any updates or terminations.

Signature: _____ Date: _____ / _____ / _____