

CHILD HISTORY FORM:

Chiropractic Associates of Rochester

Take Charge of Your Health

PRESENT DATE: _____

PLEASE COMPLETE THIS DETAILED HISTORY FORM AND RETURN IT TO THE RECEPTIONIST. SHOULD YOU REQUIRE ANY ASSISTANCE, PLEASE LET US KNOW, AS WE WOULD BE HAPPY TO ASSIST.

NAME _____ TELEPHONE # _____

ADDRESS _____ POSTAL CODE _____

DATE OF BIRTH _____ REFERRED BY _____

INS CARD # _____

Present MD _____

Date of last MD visit & reason: _____ Previous

DC name and last visit: _____

E-mail address: _____

AUTHORIZATION FOR CARE OF A MINOR

PARENT (S) NAMES _____ Work Telephone _____

I hereby authorize and consent to the chiropractic evaluation and care of my child

Parent/Guardian signature _____ Witness _____

CHIEF HEALTH CONCERNS:

REASON FOR CONTACTING US: _____

LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT

(including medications) _____

Date of Onset ____ / ____ / ____ Onset was: Sudden / Gradual / Associated with an event

Duration of problem (episode) _____ minutes / hours / days / months / years

Pattern of problem: _____ Constant / Intermittent / Occasional / Cyclical

Initiating factors: _____

Aggravating factors: _____

Relieving factors: _____

Effects of problems on body function and daily activities: _____

Prior occurrence or episodes: _____

OTHER HEALTH CONCERNS or QUESTIONS: _____

HISTORY OF BIRTH:

Hospital: _____ birthing center: home: _____ medical: _____ midwife _____
Duration of Gestation _____ weeks
Assisted birth? No / Yes _____ If yes, forceps / vacuum extraction / c-section / induced labour _____
Medications delivered to mother at birth? No / Yes. If yes what? _____
Duration of birth: _____
Complications at birth: No / Yes. Explain _____
Was delivery normal? Yes / No _____
APGAR at BIRTH _____ AFTER 5 MINUTES _____
BIRTH WEIGHT _____ BIRTH LENGTH _____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? Yes / No _____
(Explain) _____
At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____ Sit alone _____
Teethe _____ Crawl _____ Walk _____
Does sleeping pattern seem normal to you: Yes / No Explain _____
Any health problems (cancer, diabetes, heart disease, etc.) on the mothers' side of the family? _____
On the fathers? _____ With siblings? _____
Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

CHEMICAL STRESSORS:

Was the baby breast-fed? No / Yes How long _____
Formula introduced at aged _____ Type of formula used _____ Introduction to milk at age _____
Began solid foods at age _____ Type _____ Age & type of commercial baby food introduction _____
Food / Juice intolerance? No / Yes Type: _____
During pregnancy did the mother smoke? Yes / No _____
Did the mother drink alcohol? Yes / No _____
Any illness of the mother during pregnancy: _____
Any supplements taken by mother during pregnancy: _____
Any drugs taken during pregnancy: _____
Any exposures to ultrasound: No/ Yes. If so, how many & what was the medical reason? _____
Any invasive procedures (amniocentesis, CVS): _____
Any pets at home: No / Yes _____
Any smokers in the home: No / Yes (How much) _____
Any vaccinations: Which ones and any reactions: _____
Any antibiotics: No / Yes Explain: _____ Total
number of courses of antibiotics to date: _____

PSYCHOSOCIAL STRESSORS:

Any difficulties with lactation: No / Yes _____
Any problems with bonding: No / Yes _____
Any behavioral problems: No / Yes Onset: _____
Any night terrors, sleep walking, difficulty sleeping No / Yes Specify _____
Age of child when began daycare: _____
Average number of hours of television/week _____ Does your
child seem normal for their age? Yes/ No Explain _____

TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents) _____ Any
evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around
neck, other... _____ Any falls from couches, beds, change
tables _____ Any traumas with bruising, cuts, stitches,
fractures _____
Any hospitalizations: No / Yes Explain _____ Any
surgeries or organs removed _____
Sports played and age began _____
Number of hours per week played _____
Weight of school backpack _____ Approximate hours spent at play per week _____

Thank you for completing this form. We look forward to treating you.

Chiropractic Associates of Rochester

Patient's Name _____

Date _____

OVERALL HEALTH HISTORY

- Do you have vertigo (dizziness)? YES _____ NO _____
- Do you pass out easily (faint, loss of consciousness)? YES _____ NO _____
- Do you have double vision or have you lost sight in one eye? YES _____ NO _____
- Do you have any slurred speech or difficulty in arranging words properly? YES _____ NO _____
- Have you had any difficulty walking, with coordination or falling to one side? YES _____ NO _____
- Do you have any nausea or vomiting? YES _____ NO _____
- Do you have numbness on one side of you face or body? YES _____ NO _____
- Do you have any visual disturbances or rapid eye movement? YES _____ NO _____
- Do you have a headache or head pain that is unlike any you have had before? YES _____ NO _____
- Do you have headaches for hours or days? YES _____ NO _____
- Do you have history of stroke in the family? YES _____ NO _____
- Do you have chest pain? YES _____ NO _____
- Do you have any change in bowel or bladder habits? YES _____ NO _____
- Do you have a sore that does not heal? YES _____ NO _____
- Do you have any unusual bleeding or discharge? YES _____ NO _____
- Do you have any thickening in your breasts or elsewhere? YES _____ NO _____
- Do you have indigestion or difficulty swallowing? YES _____ NO _____
- Do you have a change in any wart or mole? YES _____ NO _____
- Do you have a nagging cough or hoarseness? YES _____ NO _____
- Do you have night sweats? YES _____ NO _____
- Do you have pain in the neck, jaw or face? YES _____ NO _____
- Do you have a drooping eyelid or changes in your pupils? YES _____ NO _____
- Do you have any ringing in your ears? YES _____ NO _____
- Do you take birth control pills? YES _____ NO _____

PROBLEMSPECIFIC

- Head: headaches y / n location _____
- Neck: difficulty with: turning L--R--forward--backward--tilt right--tilt left
- Midback: pain with cough, sneeze or bowel movement
- Low Back: pain down the buttock--legspain with cough sneeze or bowel movement
- Shoulder: _____
- Elbow: _____
- Wrist: _____
- Hand/Fingers: _____
- Hip: _____
- Knee: _____
- Ankle: _____
- Foot/Toes: _____



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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years that have been demonstrated to be a highly effective treatment for spinal pain, headaches and other symptoms. Maintaining spinal alignment through chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatment, medications and procedures given for the same condition.

I acknowledge that I have received information regarding my condition and proposed chiropractic treatment as well as alternative courses of care, the benefits, the risks, the side effects of treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to: muscle strains & sprains, fractures, dislocations, disc injuries and strokes. I wish to rely on the doctor to exercise judgment during the course of the treatment that he feels at the time based upon the facts then known, is in my best interests.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to apply to all my present and future chiropractic care in this office.

Patient Signature _____ Date _____

Witness _____ Date _____



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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date: _____

<u>USE</u>	Date	Initials	Reason

OFFICE
ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Office Financial Agreement 2026

Insurance policies are individualized per each patients benefit. Please read and initial next to your benefit plan.

INDIVIDUAL POLICY

_____ **Excellus BC/BS, Aetna and United:** Deductibles: Referral may be needed. Until your annual deductible is met, the insurance fee schedule will be procedure-dependent. Once the deductible is met, you will be responsible for the co-insurance policy dependent. Your co-pay is due at the time of service and will range from \$0-\$70, depending upon your contract. Insurance covers acute care and not maintenance care. Supplements are not covered and are the patient's responsibility.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United:** Authorization may be required. Some insurances set a number of visits allowed. Some costs are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care, not maintenance care.

_____ **Medicare:** No referral needed. Until your annual deductible of \$283.00 is met, the insurance fee schedule is \$50-\$100.00. You will be responsible for any usual and customary fee (ABN). Your insurance covers acute care and no maintenance care.

_____ **MVP/Cigna/Other:** The doctors in this office are out of network providers. Payment follows the Usual and Customary Fee shown below.

_____ **Usual & Customary Fees:** First visit for consultation, history and examination is \$100.00. Subsequent visits thereafter are \$50.00.

_____ **Maintenance Care:** Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. This is a service not covered as per your insurance company policy, and you will be responsible for the office fee of \$50. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre-complaint status or plateaued in improvement.

OFFICE POLICY

_____ **New Patient Appointment Fee: \$50**
All new patients will be charged a \$50 appointment holding fee that will be credited towards your total bill.

_____ **Consultation Fee: \$50**
No treatment | 15 Minute Appointment

_____ **Missed/ Cancelled Visit w/in 24 Hrs : \$50**
All patients are subject to adhere to a \$50 charge without notice of a missed or cancelled appointment.

_____ **No Insurance | Self Pay: \$100 | \$50**
Each visit will be \$50 for all current patients. If you are a New Patient, your initial evaluation will be \$100, then \$50 thereafter per visit.

_____ **Our office does not allow a personal balance over \$100. Should your account become 30 days delinquent, a \$10 charge per week will be assessed to the outstanding balance.**

_____ **Payment is due at the time of service. Payment in the form of cash, credit or check is accepted. All major credit cards are accepted.**

_____ **Returned checks will have a \$25 service charge.**

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

Responsible Party Signature

Date

Printed Name



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AUTHORIZATION FOR RELEASE OF INFORMATION:

OFFICE USE ONLY

TO: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____
_____ X-Rays and / or report of findings, CT scans, MRI's
_____ Consult reports from specialists
_____ Test Results
_____ Billing Records
_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____ Date of Birth: _____

Signature of Patient _____ Date: _____

If under age 18 Signature of Guardian: _____ Date: _____

Relationship to Patient: _____