Swan Lake Chiropractic

724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

Confidential Pediatric Patient Case History

Date of Birth: _____ Age: _____

□ Male □ Female No. of Siblings: _____

Birth Length _____ Current Length: _____

Birth Weight: _____ Current Weight: _____

Child's Name: _____ (*Preferred*): _____

Parents Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell: _____

Home Phone: _____ Work Phone: _____ Referred By: _____

Problems during pregnancy: _____

Problems during labor/delivery: _____

Congenital anomalies/Defects? _____

Number of hours sleeping per night: _____ Quality of Sleep: □ Good □Fair □Poor

Pediatrician/Family MD: _____

Immunization History:_____

Number of doses of Antibiotics your child has taken: In the Past 6 Months _____ During his/her lifetime _____

Previous Chiropractor: _____ Last Adjustment _____

Purpose this of Visit: _____

Has your child ever been treated on an emergency basis: □ Yes □ No – If yes, explain: _____

_____

Delivery/Birth History: _____

_____

_____

_____

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

Financial Awareness and Consent: I understand that I am financially responsible for all charges incurred by me, whether or not my insurance company pays. I hereby assign my insurance benefits to Swan Lake Chiropractic Health Centre. I also authorize any protected heath information required to secure payment.

Printed Name: _____ Date: _____

Responsible Party's Signature, since patient is a minor: _____

Please check off ALL that apply to your child:

__Headaches
__Dizziness
__Fainting
__Seizures/Convulsions
__Heart Trouble
__Chronic Earaches
__Sinus Trouble
__Asthma
__Colds/Flu
__Colic
__Orthopedic Problems
__Neck Problems
__Arm Problems
__Leg Problems
__Joint Problems
__Backaches
__Direct head trauma
__Poor Posture
__Scoliosis
__Walking Trouble
__Broken Bones
__Digestive disorders
__Poor Appetite
__Stomach Aches
__Reflux
__Constipation
__Diarrhea
__Diabetes
__Hypertension
__Anemia
__Bed Wetting
__ Behavioral Problems
__ADD/ADHD
__Ruptures/Hernia
__Muscle Pain
__Growing Pains
__Allergies

Has this child ever suffered the following spinal traumas?

__ Fall in Baby Walker
__ Fall from Crib
__ Fall from Highchair
__ Fall from Changing table
__ Fall from Bed or Couch
__ Fall off Swing
__ Fall off Slide
__ Fall off Monkey Bars
__ Fall off skateboard or skates
__ Fall off bicycle
__ Fall Down Stairs
__ Other _____

Has this child ever sustained an injury playing organized sports? □ Yes □ No – If yes, explain: _____

_____

Has this child ever sustained injuries in an auto accident? □ Yes □ No – If yes, explain: _____

_____

Present History: _____

_____

_____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

PLEASE READ - Appointment Policy: Our time together is important. Please do your best to arrive on time for all of your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. *If you arrive more than 5 minutes late to our scheduled time together, we may have to reschedule your appointment for another time or day.* Guardian Initials: _____

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Please read our PAYMENT GUIDELINES and select one of the following options:

_____ Self Pay Plan – I, the patient, understand that I am responsible for all charges accrued from office visits. Payment is required when services are rendered. No third party is involved. A receipt or superbill can be generated for me to pursue my own reimbursement.

_____ Medical Insurance Plan – I hereby authorize the assignment of benefits to Swan Lake Chiropractic as well as the release of any medical information necessary for the payment of claims. I, the patient, am responsible for any co-pays or deductibles due at the time the services are rendered. If after 90 days Swan Lake Chiropractic is unsuccessful recovering monies from my insurance carrier, I understand that I am ultimately responsible for charges accrued from office visits, etc.

I have read and understand the payment policy of Swan Lake Chiropractic Health Centre as explained in the PAYMENT GUIDELINES. I also acknowledge that all charges incurred in this office are ultimately my responsibility.

Name: _____ Date: _____

Signature: _____

Please read our NO-SHOW/LATE CANCELLATION policy:

If a patient fails to appear at the time of their appointment and has not contacted our office with at least 3 hours' notice, they will be considered a No Show. Because we understand life happens and obstacles come up that are beyond your control, we will not charge any fee for the first No Show. We will, however, contact you for a credit card number to keep on file so we have means of collecting a fee if it happens a second time.

Any patient who fails to appear at their appointment, who cancels/reschedules within a 3-hour period for a second time, or who is more than 5 minutes late for their appointment will be charged our full adjustment rate of $60. This same charge will be applied for any subsequent No Shows. The fee will be charged immediately on the card on file.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In such instances, please contact us before the appointment and we will waive the No Show fee when appropriate.

Signature: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have been notified of my option to receive a copy of this office's Notice of Privacy Practices and that this practice abides by those policies.

_____ (Signature)

_____ (Date)

_____ FOR OFFICE USE ONLY _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtainment
- An emergency situation prevented us from obtainment
- Other (please specify):

_____