ENLIGHTEN
CHIROPRACTIC

Name_____Date of Birth_____/_____/_____Age_____ Male / Female

Address_____City_____State_____Zip_____

Parent/Guardian Name(s)_____Relationship(s)_____

Phone Number_____Siblings_____

Social Security Number_____Height_____Weight_____

Who may we thank for referring you?_____

LIST HEALTH CONCERNS BELOW:

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor?_____Medical Doctor?_____Other_____

Who and When?_____

Result of Care_____

PLEASE MARK "**P**" FOR IN THE **PAST** OR MARK "**C**" FOR **CURRENTLY** HAVE:

___HEADACHE/MIGRAINE
___EAR INFECTIONS
___SCOLIOSIS
___ADD/ADHD
___BED WETTING
___DEVELOPMENTAL DELAY
___GROWING PAINS
___SCOLIOSIS
___SEIZURES
___SINUS ISSUES
___ASTHMA
___COLIC

___HEARING LOSS
___SLEEP PROBLEMS
___EATING PROBLEMS
___GASTRIC REFLUX
___ANXIETY
___DEPRESSION
___NERVOUSNESS
___CONSTIPATION
___DIARRHEA
___NAUSEA
___ALLERGIES
___SKIN PROBLEMS

___LOSS OF ENERGY
___POOR POSTURE
___TEMPER TANTRUMS
___AUTISM/ASD
___FREQUENT COLDS
___DIABETES
___LEG/ARM/JOINT PAIN
___JAW PAIN
___ULCERS
___RINGING IN THE EARS
___DOUBLE/BLURRY VISION
___DIZZINESS

___LOSS OF BALANCE
___BACK/NECK PAIN
___BLADDER PROBLEMS
___DIGESTIVE PROBLEMS
___HEART PROBLEMS
___KIDNEY PROBLEMS
___THYROID PROBLEMS
___INJURY FROM ACTIVITY
ANY KNOWN DIAGNOSES__
_____
_____
_____

Name:_____ DOB: _____

Please describe your child's pregnancy

Briefly describe your pregnancy_____

Any pregnancy complications?_____

Any drugs/medication during pregnancy?_____

Other information_____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section None

Induced Labor? YES / NO

If yes, please explain_____

Medications received during delivery_____

Other information_____ _____

Post Partum Information

Birth Weight_____Birth Length_____APGAR SCORE_____

Breast Fed? YES / NO How long?_____ Formula Fed? YES / NO How Long?_____

Age Introduced to Solid Foods_____

Food Allergies or Intolerances_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____Total lifetime_____

Current prescription medication/dosage?_____

Over the counter medication (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years_____

Trauma Information

Has your child ever been knocked unconscious? YES / NO Fractured A Bone? YES / NO

If yes to either, please describe_____

"According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)"

Did your child have a fall similar to what was described above? YES / NO

Explain_____

Name:_____ DOB: _____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If there is more than one condition, please answer each question for each individual complaint and indicate the score of each complaint.

EX: No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Headache Hip Pain

1. How would you rate the symptom/pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is the typical or AVERAGE of the symptom/pain? (How bad is the symptom/pain throughout most of a day?)

0 1 2 3 4 5 6 7 8 9 10

3. What is the symptom/pain level at its BEST? (How close to 0 does the symptom/pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the symptoms/pain at its best? _____%

4. What is the symptom/pain level at its WORST? (How close to 10 does the symptom/pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of awake hours is the pain at its worst?_____%

Activities of Daily Life

Please identify how your child's ability to carry out activities that are routinely part of life are affected by current condition

ACTIVITIES:	EFFECT:			
Holding Head Up	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Tummy Time	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Nursing	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Sitting Up	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Crawling	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Standing Alone	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Walking Alone	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Other: _____	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform
Other: _____	□ No Effect	□ Difficult/Painful	□ Limited/Very Painful	□ Unable to Perform

OTHER RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:
_____	_____	_____
_____	_____	_____

Name:_____ DOB: _____

Notice of Privacy Practices Acknowledgement

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature:_____ Date:_____

Written Consent for a Minor

I AUTHORIZE DR. KATIE MULLER AND ANY ENLIGHTEN CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY ENLIGHTEN CHIROPRACTIC.

_____
Minor's Name

_____ _____ _____/_____/_____
Parent/Guardian Name Parent/Guardian Signature Date

_____
Relationship to Minor / Child

Name:_____ DOB: _____

Authorization for Use or Disclosure of Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Enlighten Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images and/or testimonial will be used for: *In-office material*, *Merchandise*, *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Treatment Conditions:
I understand that the practice cannot and will not condition treatment based on whether or not I sign this authorization.

Parent/ Guardian_____

Date_____

Signature_____

Medical Information Release Form

Name_____Date of Birth_____/_____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

_____ _____/_____/_____

Parent/Guardian Signature Date

Name:_____ DOB: _____

Informed Consent for Chiropractic Care

When a practice member seeks chiropractic health care. and we accept a practice member for such care, it is essential for both to be working for the same objective. It is important that each understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a practice member, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Other joints in the arms, legs, and jaw are also subject to these same changes. While other healing professions can provide exceptional supplemental and rehabilitative services, there is no alternative to the training a chiropractor receives in the specific detection and correction of subluxation. Choosing to not have these corrected may lead to progressive degeneration and dysfunction, worsening symptoms, increased pain, and increased need for medical interventions.

Subluxations are corrected by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by highly-specific manual adjustments of the spine and extremities. Adjustments are done by hand or instrument in this office.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

As with anything in life, there is always some risk involved. Due to the nature of physics and the transfer of a force and the dynamic nature of the human body, there is a low risk of trauma-like injury such bruising, soreness, sprain/strain, fracture, dislocation. Sometimes, in the healing process, symptoms can worsen before they begin to improve. Enlighten Chiropractic team members are trained to recognize underlying conditions that may contribute to these events. Dr. Katie Muller has received specific technique training to greatly decrease the risk of these events occurring. Your health and well-being is our is greatest priority.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____/_____/_____
Parent/Guardian Name	Parent/Guardian Signature	Date