Date _____

RIVERWOODS CHIROPRACTIC & MASSAGE PLLC

## MINOR PATIENT INFORMATION

Thank you for choosing our practice for your child's chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance, we are happy to help. Please complete this form in ink.

Child's Full Name _____

Birth Date _____ Age _____ Male/Female Height _____ Weight _____ SSN _____

Child's Primary Address _____ City _____ State _____ Zip _____

Parent/ Guardian Name(s): _____

Primary Phone (_____) _____ Alt Phone (_____) _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

**Parent/Guardian Email Address (please print clearly)**_____

Whom may we thank for referring your child to us? ☐ Friend/Family _____ ☐ Doctor _____

☐ Phone Book _____ ☐ Online _____ ☐ Other_____

*** IF WE HAVE ALREADY TAKEN A COPY OF YOUR CHILD'S INSURANCE CARD PLEASE SKIP THIS SECTION ***

Does your child have insurance? ☐ Yes ☐ No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____ Group # (if applicable)_____

Who is responsible for this account? _____ Relation to patient _____

Is your child covered by an additional insurance? ☐ Yes ☐ No If yes, please fill out the information below:

Insurance Company _____ I.D. # _____ Group # (if applicable)_____

### Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the chiropractor to release any child's information including the diagnosis and the records of any treatment or examination rendered my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my child's insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my child's chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents behalf.

Signature of Parent, or Guardian _____ Date _____

Please Print name signed above _____ Relation to patient _____

1. Reason for bringing your child to our office? _____

2. Is your child here for wellness services ☐ No ☐ Yes If yes, please skip to question 9.

3. Please briefly describe the chief area of complaint, including the effects it has had on your child.

4. ( 0= no pain ) ( 10= unbearable pain ) 5. Side of Complaint: ☐ left ☐ right ☐ both ☐ central

5. How long has this complaint(s) been present? _____ 6. What do you think caused he/she complaint(s)? _____

7. Did the complaint begin: ☐ suddenly ☐ gradually 8. The complaint is % of day: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

9. Do you feel he/she's complaint(s) is getting progressively worse? ☐ No ☐ Yes, please describe _____

10. Does the pain radiate? ☐ No ☐ Yes, if yes please mark below:

**Right** ☐ upper arm ☐ forearm ☐ hand ☐ thigh ☐ calf ☐ foot

**Left** ☐ upper arm ☐ forearm ☐ hand ☐ thigh ☐ calf ☐ foot

11. Type of pain? ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting ☐ burning ☐ tingling ☐ cramps ☐ stiffness ☐ swelling ☐ other

9. What makes the pain/complaint worse? Mark all that apply.

☐ bending ☐ sitting ☐ standing ☐ walking ☐ lying down ☐ cold/damp ☐ driving
☐ lifting ☐general activity ☐ yard work ☐ gardening ☐ working ☐ turning/twisting ☐ reaching out/up/down
☐ pushing / pulling with hands ☐coughing / sneezing ☐ other _____

10. Pain he/she is experiencing is: ☐ Sharp ☐ Dull ☐ Comes & Goes ☐ Radiates ☐ Constant ☐ None

11. Since the problem started, is it: ☐ About the same ☐ Getting Better ☐ Getting Worse ☐ Other_____

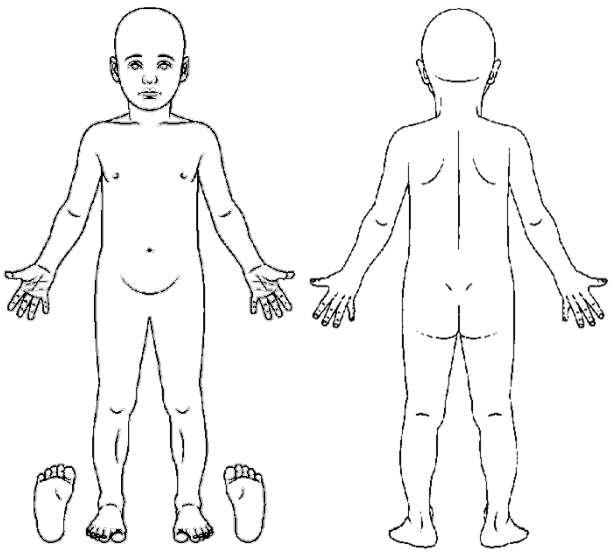
12. Are the complaint(s) previously listed worse in: ☐ morning ☐ afternoon ☐ evening ☐ non-applicable

13. Has your child had prior similar complaint(s)? ☐ No ☐ Yes, please describe _____

14a. What treatment has your child received for his/her complaint(s)? ☐ none ☐ chiropractic ☐ PT ☐ surgery ☐ meds ☐ x-rays/MRI

14b.Provider(s)_____

Please mark below the area(s) of your child's complaint(s) :



9a. Has your child had chiropractic care in the past? ☐ No ☐ Yes

9b.If yes, where and when was his/her last treatment? _____

10. Please check all the conditions below which apply to your child's personal health history:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Elbow Pain | ☐ Jaw Pain | |
| ☐ Anxiety | ☐ Ankle Pain | ☐ Epilepsy | ☐ Arm Pain |
| ☐ Knee Pain | ☐ Shoulder Pain | ☐ Pneumonia | ☐ Eye/Vision Problems |
| ☐ Fainting | ☐ Leg Pain | ☐ Asthma | ☐ Back Pain |
| ☐ Sleep Apnea | ☐ Foot Pain | ☐ Headaches | ☐ Kidney Disease |
| ☐ Broken Bones | ☐ Sprain/Strain | ☐ Mono | ☐ Cancer |
| ☐ Hand Pain | ☐ Allergies | ☐ Chest Pain | ☐ Minor Heart Trouble |
| ☐ Mumps | ☐ Chicken Pox | ☐ Depression | ☐ Hearing Problems |
| ☐ Neck Pain | ☐ Tumor | ☐ Hepatitis | ☐ Spinal Cord Injury |
| ☐ Ulcer(s) | ☐ Diabetes | ☐ Wrist Pain | ☐ Neurological Disorder |
| ☐ Dizziness | ☐ Hip Pain | ☐ Other _____ | |

11a. Has your child ever been involved in an auto accident? ☐ No ☐ Yes, when? _____

11b. Was he/she treated? ☐ No ☐ Yes, by whom _____

12. List any past significant injuries with dates _____

13. List any surgeries/hospitalizations with dates _____

14. List your child's medications and/or vitamins _____

RIVERWOODS CHIROPRACTIC & MASSAGE PLLC

CONSENT & TERMS OF ACCEPTANCE

I consent to the use or disclosure of my protected health information by Riverwoods Chiropractic & Massage, PLLC for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Riverwoods Chiropractic & Massage, PLLC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Riverwoods Chiropractic & Massage, PLLC is not required to agree to the restrictions that I may request. However, if Riverwoods Chiropractic & Massage, PLLC agrees to a restriction that I request, the restriction is binding on Riverwoods Chiropractic & Massage, PLLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Riverwoods Chiropractic & Massage, PLLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have a right to review Riverwoods Chiropractic & Massage, PLLC's Notice of Privacy Practices prior to signing this document.

The Riverwoods Chiropractic & Massage, PLLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Riverwoods Chiropractic & Massage, PLLC.

The Notice of Privacy Practices for Riverwoods Chiropractic & Massage, PLLC is also provided at – 820 Ocean Beach Hwy, Ste 116, Longview, WA 98632-4081. Riverwoods Chiropractic & Massage, PLLC reserves the right to change the privacy practices that are described within the Notice of Privacy Practices. I may obtain a revised copy by request in the mail or at the time of my next appointment to the office at Riverwoods Chiropractic & Massage, PLLC.

I understand that Riverwoods Chiropractic & Massage, PLLC does not offer to diagnose or treat any disease. Riverwoods Chiropractic & Massage, PLLC only offers to diagnosis either vertebral subluxations or neruo-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, Riverwoods Chiropractic & Massage, PLLC will advise me. I know that if I desire advice, diagnosis or treatment for those findings, Riverwoods Chiropractic & Massage, PLLC will recommend that I seek the services of another health care provider.

I consent to the rendering of care, including diagnostic procedures and treatment given by Harold West, DC at Riverwoods Chiropractic & Massage, PLLC. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I have read this form and certify that I understand its contents. This consent may be rescinded in writing at any time.

I, _____ have read and fully understand the above statements.
**(PRINT NAME)**

_____ _____
**(SIGNATURE)** **(DATE)**