NEW PEDIATRIC CHIROPRACTIC PATIENT
5540 PGA Boulevard
Suite 100
Palm Beach Gardens, Florida 33418
www.namastechiropractic.com
office: 561-619-7319
fax: 561-619-7325

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New Pediatric Chiropractic Patient Form

WELCOME!

How did you hear about us? _____

Please provide us with the following information:

Patient First Name:		**Last Name:**	
Birthdate:	**Age:**	**Sex/Gender:**	**# of Siblings:**
Mother's Name:		**D.O.B.**	
Father's Name:		**D.O.B.**	
Address:			
City:		**State:**	**Zip:**
Parent #1 Phone:		**Parent #1 Email:**	
Parent #2 Phone:		**Parent #2 Email:**	

GENERAL INFORMATION

OBGYN / Midwife Name (Mother's):	**Pediatrician Name:**
Date of last Pediatric Visit:	**Purpose:**

Immunizations: *(Please circle one)*

Yes / No

TODAY'S VISIT

Purpose of today's Visit ☐ **Wellness Check** ☐ **Injury / Accident** ☐ **Other**

If "other", please explain:

Previous Chiropractic Care: *(please circle one)* **Yes / No**

Chiropractor Name: *(if "Yes" circled above)*

Date of last Chiropractic Visit:	**Purpose:**

DELIVERY HISTORY

Delivery History (Check which applies)	☐ **Vaginal**	☐ **C-Section**	☐ **Forceps**	☐ **Suction**

Birth Weight:	**Birth Length:**	**Current Weight:**	**Current Height:**

HISTORY

Has Your Child Experienced Any of the Following? *(please check all that apply)*

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Problem
- ☐ Heart Trouble
- ☐ Chronic Earaches/Infections
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Cold / Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Behavioral Problems
- ☐ ADD / ADHD
- ☐ Rupture / Hernia
- ☐ Muscle Pain
- ☐ Growing Pains

Has Your Child Experienced Any of the Following Spinal Traumas? *(please check all that apply)*

- ☐ Fall in Baby Walker
- ☐ Fall from Chair
- ☐ Fall from Bed or Couch
- ☐ Fall off Swing
- ☐ Fall off Monkey Bars
- ☐ Fall off Skateboard / Skates
- ☐ Fall off Bicycle
- ☐ Fall Down Stairs
- ☐ Other Fall / Trauma

HISTORY *(cont.)*

Does Your Child Suffer from Allergies: *(please circle one)* **Yes / No**

If "Yes", Please list:

Has Child Ever Experienced an Injury Playing Sports? *(please circle one)* **Yes / No**

If "Yes", Please briefly explain:

Has Child Ever Been Involved in an Automobile Accident? *(please circle one)* **Yes / No**

If "Yes", Please briefly explain:

Has Child Ever Required Surgery? *(please circle one)* **Yes / No**

If "Yes", Please briefly explain:

Is Child Currently Taking any Medications? *(please circle one)* **Yes / No**

If "Yes", Please list medication(s):

Is Child Currently Taking any Vitamins/Supplements? *(please circle one)* **Yes / No**

If "Yes", Please list medication(s):

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Treatment Consent Form

Consent for Treatment

I hereby give my consent for Namaste Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) such as:

- release of information to family physicians and employer
- release of information to insurance companies
- taking photographs and x-rays to be used for treatment purposes
- perform other diagnostic and therapeutic procedures for treatment purposes

I authorize my insurance benefits to be paid directly to:

Namaste Chiropractic
5540 PGA Boulevard Suite 100
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I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, fees for professional services rendered me will be IMMEDIATELY due and payable. I agree that I will be responsible for all attorney a legal fees if legal action becomes necessary to collect unpaid debts.

Payment Policies

PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.

At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Consent to Treatment of Minor Child (*if applicable*)

I hereby authorize Namaste Chiropractic to administer treatment as they so deem necessary to my son/daughter/other,

_____ .
(Print Patient Name)

_____ _____
(Parent or Guardian Signature) (Date)

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TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____ have read and fully understand the above statement.
(*print name*)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
(*patient signature*) (*date*)

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Chiropractic Informed Consent Form

Namaste Chiropractic Purpose of Treatment

The doctors at Namaste Chiropractic aim to provide chiropractic care to promote your health and well-being. This care may include, but is not limited to, consultation, examination, spinal adjustments, manual therapies, physical therapy modalities, diagnostic X-rays, or other procedures deemed necessary for your specific condition.

Benefits of Chiropractic Care

Chiropractic care may help alleviate pain, improve joint mobility, enhance physical function, and support overall wellness. The specific benefits will depend on your individual condition and response to treatment.

Risks of Chiropractic Care

As with any healthcare intervention, chiropractic care carries some risks, though these are typically minimal. Reported complications, while rare, may include:

- Sprains or strains
- Irritation or aggravation of a disc condition
- Dislocations
- In extremely rare cases, fractures or other serious injuries

I understand that, as in the practice of medicine, chiropractic care cannot guarantee results, and unforeseen risks or complications may occur. I do not expect the doctor to anticipate or explain all possible risks and complications. I rely on the doctor to exercise professional judgment in my best interest during the course of treatment, based on the facts known at the time.

Consent to Treatment

I, _____, have read and understand the above information regarding the purpose, benefits, and risks of chiropractic care. I hereby authorize the doctors of Namaste Chiropractic to administer chiropractic care as deemed necessary for my condition. I acknowledge that I am voluntarily consenting to treatment and accept the associated risks and benefits. I understand that I may discontinue treatment at any time.

PRINT NAME _____ **SIGNATURE** _____ **DATE** _____

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Please read and sign this document *only* after you have read the

HIPAA Notice of Privacy Practices

located on the Namaste Chiropractic website under the "Patient Center" tab or you have viewed this form in our office.

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Namaste Chiropractic

I, _____ have read a copy of Namaste Chiropractic's Notice
(*print patient name*)

of Patient Privacy Practices.

_____ _____
(Signature of Patient or Parent or Legal Guardian) (*Date*)

Who may Namaste Chiropractic have permission to speak with about your chiropractic health care?

NAME	RELATIONSHIP	PHONE NUMBER

How may we contact you? *Check all that to apply.* (*We value your privacy and never share or sell information with any 3rd parties.*)

- ☐ Phone
- ☐ Text
- ☐ Email

If you would like to retain a hardcopy of the HIPAA NOTICE of PRIVACY PRACTICES, please print from our website or request a copy in our office.