# PATIENT HEALTH RECORD CHILD

## ABOUT THE CHILD

Name ___________________________________________

Address ________________________________________

City ________________ State______ Zip___________

Home phone _____________________________________

Birth date ___________________

SS#____________________________________________

Age _________ Gender Weight___________

## ABOUT THE PARENT

Name___________________________________________

Employer________________________________________

Work address ____________________________________

Work phone __________________Cell__________________

Type of work ____________________________________

E-mail address___________________________________

Social Security # ________________________________

Insurance Co:____________________________________

Insured's Name:__________________________________

Insured's SS#:_______________________ DOB:_________

## VACCINATIONS

Have you chosen to vaccinate your child? **Yes** **No**

If yes, circle all that your child has received.

**DPT** **MMR** **Chicken Pox** **Hepatitis** **Other**

Describe any and all reactions to vaccine(s). _____________

_____________________________________________________

## REASON FOR THIS VISIT

Describe the purpose of this visit ________________

__________________________________________

Is the purpose of this appointment related to

**Sports** **Auto** **Fall** **Home Injury** **Other**

Please explain ______________________________

When did this condition begin? __________________

Has this condition:

**Gotten worse** **Stayed constant** **Comes and goes**

Does this condition interfere with:

**Sleep** **Daily routine** **Other activities**

Please explain ______________________________

__________________________________________

Has this condition occurred before? **Yes** **No**

Please explain ______________________________

Have you seen other doctors for this condition? **Yes** **No**

Doctor's Name(s) ___________________________

Type of treatment ___________________________

Results ____________________________________

## AWARENESS OF CHIROPRACTIC PRINCIPLES

| Were you aware that | Yes | No |
|---|---|---|
| * Doctors of Chiropractic work with the nervous system? | ☐ | ☐ |
| * The nervous system controls all bodily functions and systems? | ☐ | ☐ |
| * Chiropractic is the largest natural healing profession in the world? | ☐ | ☐ |
| * If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? | ☐ | ☐ |

## EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ______________________________________

Have you been adjusted by a Chiropractor before? **Yes** **No** Reason for those visits? ____________________

Doctor's name________________________________ Approximate date of last visit ____________

Has any adult in your family seen a Chiropractor? **Yes** **No**

Has any child in your family seen a Chiropractor? **Yes** **No**

## MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain ________________________________

Any illness during your pregnancy?_____________________

__________________________________________________

How was your delivery? ______________________________

☐ Labor chemically induced ☐ Labor was Dr. assisted
☐ C-section delivery ☐ Forceps/Vacuum extraction?
☐ Did Dr. pull or twist baby? ☐ Premature delivery

Please explain ______________________________________

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Vaccinations? **Yes No**

## CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in the ears
☐ Vision problems
☐

Other

## CHILD'S CURRENT HEALTH STATUS

| | No | Yes | If Yes, please explain |
|---|---|---|---|
| Has your child ever: | | | |
| …taken antibiotics? | ☐ | ☐ | ______________________ |
| …been hospitalized? | ☐ | ☐ | ______________________ |
| …had a severe fall? | ☐ | ☐ | ______________________ |
| …been in a car accident? | ☐ | ☐ | ______________________ |
| Is your child | | | |
| …accident prone? | ☐ | ☐ | ______________________ |
| Had Surgery? Please Explain… | | | ______________________ |
| …currently taking any medication (s)? | ☐ | ☐ | ______________________ |
| …having difficulty interacting with others? | ☐ | ☐ | ______________________ |

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

________________________________________________________________________

What changes (if any) in your child's health or behavior would you like accomplished? ________________

________________________________________________________________________

## AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Lund Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian:______________________________________________Date:__________________________

# HISTORY AND EVALUATION

**Chief Concerns**:______________________________________________

______________________________________________

______________________________________________

**History of Condition:**______________________________________________

______________________________________________

**Birth and Delivery:**______________________________________________

**Childhood Injuries / Falls / Accidents:**______________________________________________

**Temperament / Attitude:**______________________________________________

**Sleep:**______________________ **Nutrition:**______________________

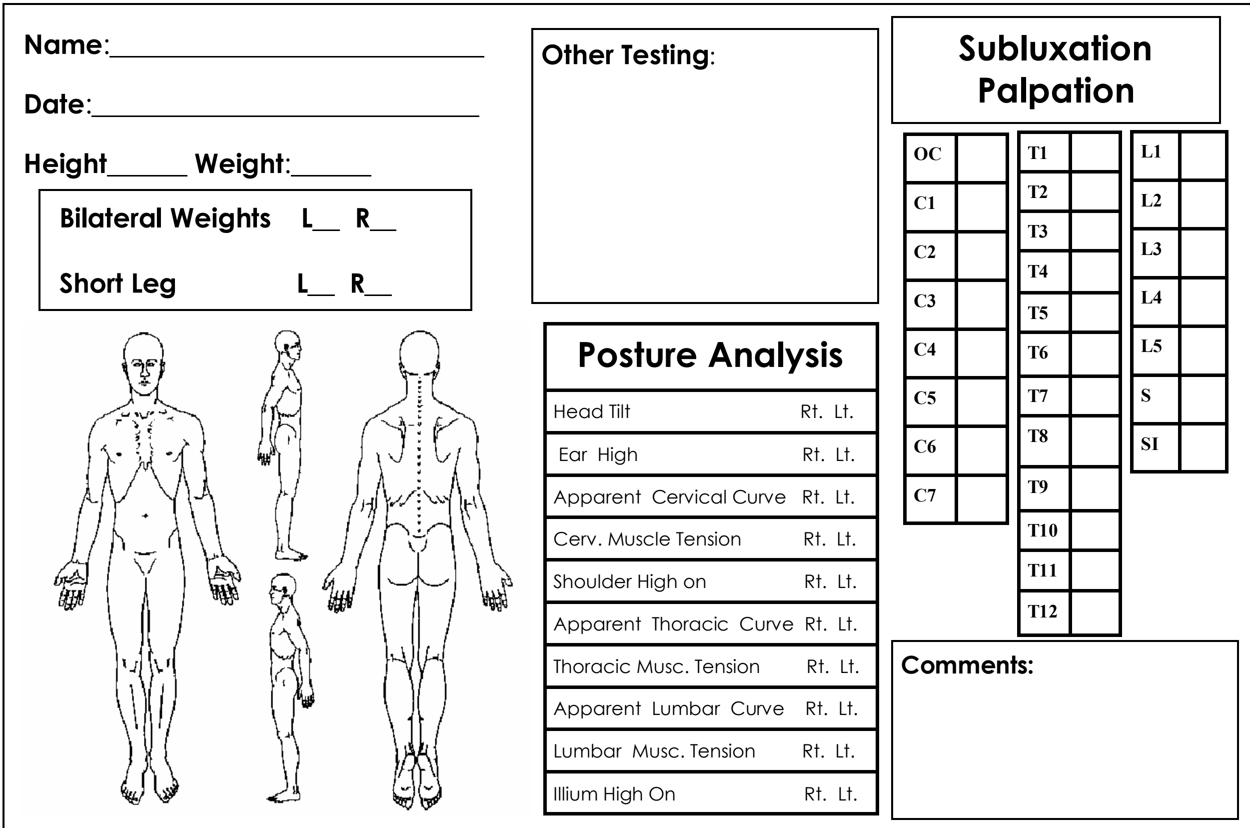
**Medications**:______________________________________________

**What has been done to help this condition (s):**______________________________________________

**Family Health History**:______________________________________________

**Other:**______________________________________________

# EXAM



**Name**:__________________________

**Date**:__________________________

**Height**______ **Weight**:______

**Bilateral Weights** L__ R__

**Short Leg** L__ R__

**Other Testing**:

## Subluxation Palpation

| | | | | | |
|---|---|---|---|---|---|
| OC | | T1 | | L1 | |
| C1 | | T2 | | L2 | |
| C2 | | T3 | | L3 | |
| C3 | | T4 | | L4 | |
| C4 | | T5 | | L5 | |
| C5 | | T6 | | S | |
| C6 | | T7 | | SI | |
| C7 | | T8 | | | |
| | | T9 | | | |
| | | T10 | | | |
| | | T11 | | | |
| | | T12 | | | |

## Posture Analysis

| | |
|---|---|
| Head Tilt | Rt. Lt. |
| Ear High | Rt. Lt. |
| Apparent Cervical Curve | Rt. Lt. |
| Cerv. Muscle Tension | Rt. Lt. |
| Shoulder High on | Rt. Lt. |
| Apparent Thoracic Curve | Rt. Lt. |
| Thoracic Musc. Tension | Rt. Lt. |
| Apparent Lumbar Curve | Rt. Lt. |
| Lumbar Musc. Tension | Rt. Lt. |
| Illium High On | Rt. Lt. |

**Comments:**

# Electronic Health Records Intake Form

*In compliance with Medicare requirements for the government EHR incentive program*

**First Name**:_________________________ **Last Name**:_________________________

**Email address:** _________________@_________________
**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer
**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ______________________________________________ Date:________________

Height: _________ Weight:____________ Blood Pressure:______ /______

# River Falls Chiropractic

Todd Frisch, D.C. and Melissa Kolb, D.C.

215 North 2nd Street, Ste 201, River Falls, WI 54022 * Phone: 715-425-6665 Fax: 715-425-6677

## Financial Disclaimer

Dear Patient,

Welcome to **River Falls Chiropractic**! We are pleased that you have chosen our clinic to address your healthcare needs. We would like to take a few minutes to explain what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may not cover all of your visits to our office. You are financially responsible for co-payments, co-insurance and deductibles for covered services. Services exceeding benefit limits or considered maintenance or preventative are not reimbursable by your plan. You are also financially responsible for all non-covered services. Please feel free to discuss any questions with our accounts department.

If your doctor feels that care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several financial plans we have available.

- If at anytime there is a change in your insurance benefits it is **YOUR RESPONSIBILITY TO NOTIFY THE FRONT DESK. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.**
- Please understand that any benefit quoted to you by this office is **NOT A GUARANTEE** that your insurance co. will make payment on your claims.

**YOUR CO-PAY, CO-INSURANCE, AND OR DEDUCTIBLE IS DUE AT THE TIME OF YOUR VISIT.** We welcome payments in advance by **cash**, **check**, **Visa**, **MasterCard**, **and debit cards.**

**Also note:** If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge you understand the services you are receiving may not be covered by your health plan, and in that situation you would be 100% responsible for all charges incurred.

_______________________________________ _____________

Signature Date

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## Non-Covered Services: Financial Disclosure Form

Chiropractic services typically covered by health insurance policies include:

Chiropractic adjustment for acute clinical conditions

Limited treatment of symptom flare-ups or exacerbations.

Services that we expect to **NOT** be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility are outlined below. Your financial responsibility is limited to services received during the treatment dates below.

**Treatment plan start date:____/____/____Treatment plan end date:____/____/___**

| Non-covered Services and Cost Per Visit* | |
|---|---|
| Exam(s) (MEDICARE/MEDICARE Replacement) | $50-75 |
| Maintenance Care Spinal Adjustments | $50 |
| X-Ray(s) to detect subluxation | $95 |
| Durable Medical Equipment (Braces, Orthotics, Ice Pack) | Depends on Product |
| Decompression Therapy | $75-150 |
| Nerve Scan | $35 |

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Name:________________________________________

Patient's Signature:________________________________________ Date:__________