



Reason for Chiropractic Check-Up

The human body is designed to be healthy. The primary system in the body which coordinates health is the nerve system. The healthy function of every cell, every system and every organ is dependent upon the integrity of the nerve system. The bones of the skull and vertebrae of the spine house and protect the central nerve system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called, **Vertebral Subluxation**.

This form will help reveal the causes of **Vertebral Subluxation**, which interfere with the optimal function of your child's nerve system and therefore impair your child's inborn health potential.

Your Child's History

Child's Name: _____ Birthdate: _____ Age: _____

Male _____ Female _____ Weight: _____ Height: _____

Address: _____ City: _____ Zip: _____

Parent's/Legal Guardian Names: _____

Parent's Phone No: _____ Work No.: _____

Siblings and ages: _____

Who referred you to our office: _____

Purpose for Contacting Us? _____

Other doctors seen for this condition(s)? Yes or No

Doctors Name(s): _____

Who is your regular Pediatrician? _____

Prior Treatment(s): _____

Turn-over

Vertebral Subluxation Assessment

1) Has your child been checked by a Doctor of Chiropractic? Yes or NO

Reason: _____

Chiropractor(s) name and location _____

Were x-rays taken? Yes or No When? _____

2) Experts around the world agree: the birth process as we know it may cause extensive neurological trauma or damage and even death to the infant.

Did you have ultrasound during this pregnancy? Yes or No How many? _____

Any medications taken during pregnancy? Yes or No

List: _____

Place of birth: Home / Birthing Center / Hospital

Provider: Mid Wife / OB-Gyn / Other _____

Type of Birth: Vaginal / C-section. Was anesthesia used? _____ Type _____

Was labor induced? Yes or No If yes, Why? _____

What position did you deliver in: Squatting / On back / On side

Birth Trauma: Doctor assisted / Twisting, Pulling / Vacuum Extraction / Forceps

Newborn trauma or other complications (medical procedures and tests)?

Birth Weight: _____ lbs/oz. Birth Length: _____ APGAR Score: _____

3) According to the **National Safety Council** approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals that approximately 250,000 children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? Yes or No

Please Describe: _____

Any fractures, dislocations or stitches?

Has your child been in an auto accident or similar type? Yes or No

If so, when? _____ What injuries sustained? _____

4) Which sports does your child play? Soccer / Football / Gymnastics / Karate / Hockey
Basketball / Dance / Wrestling / Baseball / Others

5) Other than the avg. 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? NA- Yes or No

Is it in front of a computer? NA - Yes or No How many hours per day? _____

Is it in front of the TV? NA - Yes or No How many hours per day? _____

- 6) Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

Did you breast-feed your child? Yes or No. How long? _____. Was your decision supported by your health care provider? Yes or No

Are you currently breastfeeding your child? Yes or No How long thus far? _____

- 7) How would you rate your child's diet? Excellent – Good – Fair – Poor

Why? _____

Does your child consume artificial sweeteners? _____ Fluoridated water? _____

- 8) **Circle** any of the following conditions your child has suffered from:
Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Fevers, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Growing pains
Other _____

- 9) How often has your child been treated with drugs? _____

Were you informed of their adverse reactions? Yes or No

If it was an antibiotic, was your child cultured for its use? Yes or No Unsure

Is your child currently on any medications? (please list) _____

Any surgeries? When? NA

- 10) The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of health and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? Yes or No
Unsure

Describe reaction(s) _____

Was it reported by you to your doctor? Yes or No

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CORRECTION

Today, we are becoming more aware of how current technological lifestyles and practices expose our children's nerve systems to continuous stresses. These stresses can result in *Vertebral Subluxations*.

Current scientific research is showing the direct relationship between the function of the nerve system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct *Vertebral Subluxation*. Correction of *Vertebral Subluxation* with the chiropractic adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION FOR CHECK-UP/CARE OF A MINOR

I hereby authorize Dr. Richard S. Humiston to administer care as deemed necessary to my son / daughter.

Signed: _____ Date: _____
Parent / Legal Guardian

Witnessed by: _____ Date: _____

ASSIGNMENT, LIEN, AND AUTHORIZATION

INSURANCE BENEFITS

To whom it may concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Humiston Family Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient: _____ Date: _____

Witness: _____ Date: _____