

First Name: _____ Last Name: _____

Age: _____ Date of Birth: ___/___/___ Email: _____

Parent/Guardian's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

How were you referred to Innate Life Chiropractic? _____

Reason(s) for seeking services at Innate Life Chiropractic: _____

Please mark the following indicators: 'X' = current level of health 'O' = your *desired* level.

VERY CHALLENGED

CHALLENGED

TRANSITION

GOOD

EXCELLENT



Primary Concern (if any)? _____ **When did it begin (date)?** _____

What caused it? _____ It began: Suddenly Gradually Post-Injury

Please rate the severity of this problem on average: Low – 1 2 3 4 5 6 7 8 9 10 – High

It feels like: _____ **Please draw the area of concern ↓**

Does it move/shoot/go to any other areas of the body? Yes No

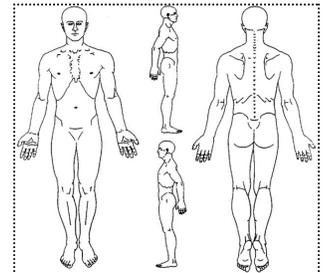
If YES, where: _____

What makes it better? _____

What makes it worse? _____

Have you/they ever had a similar condition? Yes No

If YES, Explain: _____



How often do you experience this problem? Occasionally Intermittent Frequent Constant

Is the condition: Getting Worse Staying the Same Improving Comes & Goes Unsure

Is the condition worse at times of the day? No Morning Afternoon Evening Night

Has your child received care for this condition before? (Please explain): _____

This condition is interfering with: School Sleep Hobbies Exercise Daily Routine Other: _____

What are your top 3 goals for your child?

1. _____

2. _____

3. _____

Any other goals you and your child have? (Please check all that apply)

Restore/Maintain Health More energy Better sleep Cease medication

Wellness & Prevention Improved Performance Expand Level of Well-Being

More joy and ease Reach full potential Keep up with siblings and friends

PREGNANCY & FERTILITY HISTORY

Any fertility challenges? _____
Medications during Pregnancy: _____ Cigarettes or Alcohol during Pregnancy? Yes No
Was mother ill? _____ Any ultrasounds? _____
Challenge(s) during pregnancy? _____

LABOR & DELIVERY HISTORY

Research indicates that the birth process can cause trauma to a baby's spine & nervous system. Was their birth:(check all that apply)

Home Birth center Hospital Vaginal Birth Scheduled C-Section Emergency C-Section

Please check any applicable interventions or complications:

Cord around neck Breech Induction Epidural/Pain Meds Forceps/Vacuum Episiotomy

Challenge(s) with labor/delivery? _____

At how many weeks was your child born? _____ APGAR Score: _____ Genetic Disorders: _____

Present at Birth? Jaundice Cyanosis/Respiratory Problems Feeding Problems Displaced Joints

Genetic Disorders: _____ Other: _____

GROWTH & DEVELOPMENT HISTORY

Infant Feeding: Breast Bottle Formula Quality of Sleep: Good Fair Poor

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No

Did/does your child suffer from colic, reflux, or constipation as an infant? Yes No

Have you chosen to vaccinate your child? No Yes, on a delayed schedule Yes, on schedule

Has your child been given antibiotics? Yes No If yes, how many times? _____

Night terrors or difficulty sleeping? Yes No Please explain: _____

How many hours per day do they typically spend watching TV, computer, tablet, or phone? _____

Describe your child's diet? Mostly whole, organic foods Pretty average Lots of processed foods What sports are/were they involved in? _____

Please list any medications/drugs/vitamins/herbs/other your child is taking: _____

Please check all that apply to your child and give any necessary details: Uncoordinated/Accident prone

Surgery Hospitalizations Chronic Illness(es) Emergency Visits Auto-Accidents Other Injuries

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has/is currently experiencing any of the emotional stresses below: (check all that apply)

Academic pressure Loss of a loved one Bullying Relocation Lifestyle change

Parents' divorce Loss of a pet New sibling Other: _____

Behavioral, social, or emotional issues? Yes No Please explain: _____

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? Yes No Date of last adjustment? _____
What was their speciality? Pain Relief Physical Therapy & Rehab Nutrition Nervous System-based
Reason for previous care? _____ How long under care? _____
Why did you stop care? _____

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you?

OVERALL HEALTH

Has this child ever suffered from: (check all that apply)

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Arm problems | <input type="checkbox"/> “Growing pains” |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Backaches | <input type="checkbox"/> Ruptures/hernias | <input type="checkbox"/> Stomachaches |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Chronic earaches/infections |
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heart troubles | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diabetes/hypoglycemia |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Neck problems | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Walking problems | <input type="checkbox"/> Leg problems |
| <input type="checkbox"/> Other: _____ | | | |

PLEASE CONTINUE TO THE FOLLOWING PAGES.

Agreement of Payment for Services

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. **The fee for a new patient is \$150.00, which includes a chiropractic exam, a report of findings, and the first adjustment.** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in seeking reimbursement from the insurance company, for me to submit. **I clearly understand and agree that all services rendered to me are charged directly to me. And I understand that I am personally responsible for the payment of my account.** If at any point, a patient must cancel the remainder of their care plan they are entitled to a refund of the remaining balance. A refund will not be given for services that have been previously rendered

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is *to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations.*

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will 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.

Right to Privacy

We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability Act of 1996, revised in 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

By signing this form, I understand that:

1. I agree that I am responsible to pay for all services my child receives in this office.
2. I have read and fully understand the Terms of Acceptance.
3. I understand that most care is given in an open setting. Private room available upon request.
4. A copy of Innate Life Chiropractic’s “Notice of Privacy Practices for Protected Health Information (HIPAA)” is available for my review at innatelifechiro.com/hippa/
5. I consent to receive communication in connection with my care via email, postal mail, text & phone messaging.
6. I consent to my first name& last initial being posted on the Referral Board when I refer a new patient to Innate Life Chiropractic.
7. I consent to my testimonial being used in office/electronically with my first name &last initial only.
8. I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials.
9. I have read, or have had read to me, the above Informed Consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

If you remove consent to any portion please write it here:

May we discuss your condition with any member of your family? YES NO
 If YES, please name the members allowed. Release of Information includes the diagnosis, records, and examinations rendered to me and claims information.

[] Spouse _____

[] Child _____

[] Other _____

Patient Name: _____ **Signature:** _____ **Date:** _____
Parent or Guardian: _____ **Signature:** _____ **Date:** _____

CONSENT TO TREAT A MINOR (if applicable)

I certify that I, _____, am the child’s parent and/or legal guardian and responsible for making their health care decisions. I hereby authorize Dr. Nathan Gerowitz and whomever he may designate as his assistants to administer care, as he deems necessary to my child _____.

I also grant permission for Dr. Nathan Gerowitz to provide care for my child if I am not present.

Signature _____ **Date** _____