



CHILD HISTORY FORM

Name _____ Birth Date ___/___/___ Today's Date ___/___/___

Address _____ City _____ State _____ Zip _____

Social Security # ___/___/___ Male ___ Female ___ Height _____ Weight _____

Name of Dad _____ Name of Mom _____

Home # (____) _____ Cell # (____) _____ E-Mail _____

Parents Employment _____ Occupation _____

Work # (____) _____ Referred By _____

In case of emergency contact _____

Please check if you are here for the following: ___ Family Care ___ Wellness ___ Other

Reason for consulting our office? _____

Names of other Doctors seen for this? _____ Name of Pediatrician _____

Circle all of the following that your child has had during the past SIX MONTHS:

- | | | | | |
|------------------|--------------------|------------------|--------------------|-------------|
| Ear Infections | Scoliosis | Seizures | Chronic Colds | Headaches |
| Asthma/Allergies | Digestive Problems | Recurring Fevers | Growing/Back Pains | Bed Wetting |
| Car Crash | Temper Tantrums | ADHD | Trouble Sleeping | Colic |

Family History/Health Problems _____

Number of Doses of Antibiotics Your Child Has Taken:

During Last Six Months _____ During Lifetime _____

Number of Doses of Other Prescription or Non-Prescription Drug (including Tylenol, Aspirin) Taken:

During Last Six Months _____ During Lifetime _____

Vaccine History _____

Childhood Diseases

Chicken Pox	Age ___	Mumps	Age ___
Rubella	Age ___	Whooping Cough	Age ___
Rubella	Age ___	Other _____	Age ___

Prenatal History

Name of Obstetrician/Midwife _____

Complications During Pregnancy? Y / N List _____

Ultrasounds During Pregnancy? Y / N How Many? _____

Medications During Pregnancy/Delivery? Y / N List _____

Tobacco/Alcohol During Pregnancy? Y / N List _____

Genetic Disorders or Disabilities? Y / N List _____

Birth Place? Hospital _____ Birthing Center _____ Home _____

Birth Intervention: Forceps _____ Vacuum Extraction _____ Caesarian Section _____ Planned Y / N

Birth Weight _____ Birth Length _____ APGAR Scores _____ (1 Min) _____ (5 min) _____

Feeding History

Breast Fed? Y / N How Long? _____ Formula Fed? Y / N How Long? _____ Type? _____

Introduced to Solids at _____ Months Food/Juice Allergies or Intolerances? Y / N List _____

Developmental History

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a chiropractor for early detection and correction of vertebral subluxation (nerve interference). At what age was your child able to:

____ Respond to Sound ____ Respond to Visual Stimuli ____ Hold Head Up ____ Sit Up

____ Roll Over ____ Crawl ____ Stand Alone ____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life. Has this happen to your child? Y / N

Is/has your child been involved with any high impact or contact type sports (Soccer, Football, Gymnastics, Baseball, etc.) Y/ N

List: _____

Has your child ever been involved in a car accident? Y / N Date: _____ Describe: _____

Has your child ever been seen on an emergency basis? Y / N Describe: _____

Other Traumas or Surgeries: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Blau Family Chiropractic and Dr. Kevin Blau to administer care to my child, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by Blau Family Chiropractic.

Signature

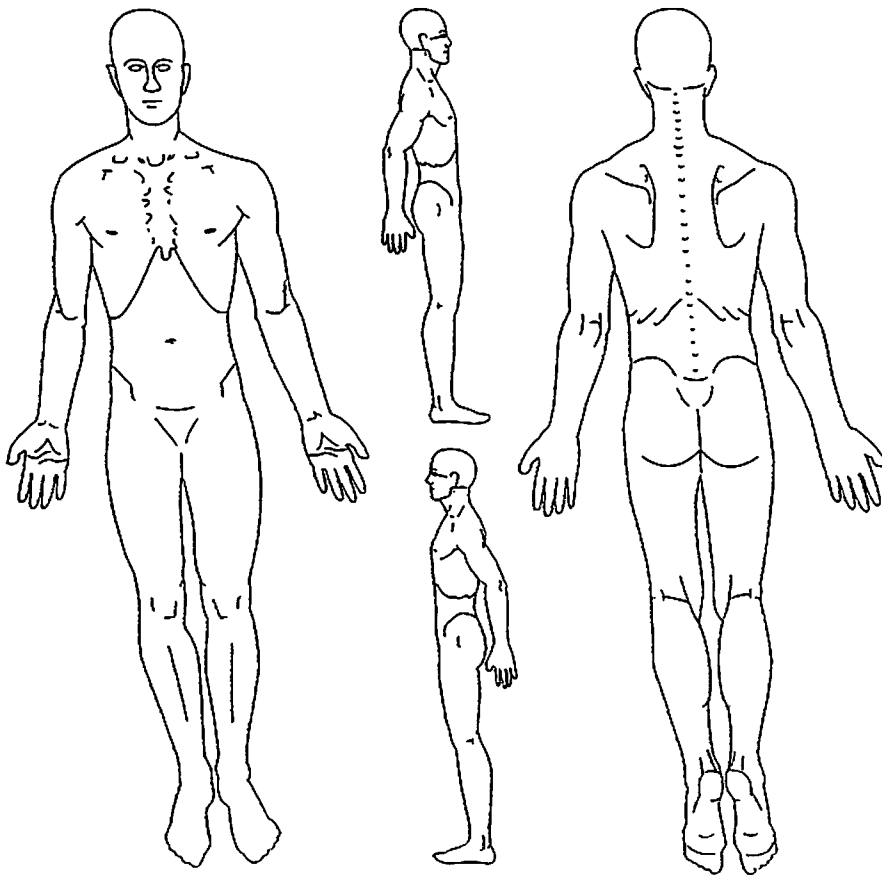
Date

Location of your discomfort

Name _____ Date: _____

Please locate the area of discomfort on the image below by using the letters shown:

- | | | | |
|----------------|--------------|-------------|---------------|
| D = Dull | S = Stabbing | B = Burning | T = Tingling |
| N = Numbness | C = Cramping | A = Aching | SH = Shooting |
| TH = Throbbing | | | |



Frequency of discomfort: Continuous Intermittent Occasional Frequent
Pain (choose one) decreases / stays the same / increases with movement.

Intensity: Please Circle

1 (no pain) 2 3 4 5 6 7 8 9 10 (unbearable)

Amount of time in discomfort: Please Circle

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Insurance Coverage</u>	<u>Paid At Time of Service</u>
Consultation	N/C	N/C
Initial Exam/Computer Scans	\$72	\$50
Dynamic Exam/Computer Scans	\$65	\$35
X-Rays (per view)	\$60	\$40
Adjustment	\$60	\$37
Light Therapy	N/A	\$35
Wellness Adjustment Plans	N/A	Varies per persons needs

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service, unless you are participating in an Active Life Plan. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report. Balances with no payment over 30 days will be charged a \$5.00 statement fee, this charge will occur each month until arrangements have been made or balance is paid in full. Patient balances over 60 days will be forwarded to a collection agency with any accrued interest.

- Cash Policy:** Payment is due at time of service or according to the plan of your choice.
- Health Insurance:** If you have Insurance that covers chiropractic care, we will send in your claims for you. Deductibles and co-pays are paid at time of service, or paid according to the plan of your choice. Remember, your agreement with your insurance company is between you and them. Please submit any requested information to them as quickly as possible. Any balance due to denied or reduced claims will be your responsibility. Having Insurance does not always guarantee payment.

If you acquire insurance for a special situation such as an auto accident or worker's compensation please let us know immediately. Once a claim is complete, you can return to your original Active Life Plan.

I have read and I understand the above policies. I have initialed the one that applies to me.

Patient Signature

Date

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.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by 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 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.

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. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

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

I therefore accept chiropractic care on this basis.

(signature)

(date)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Blau Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

Other treatment options that could be considered may include the following:

Over the counter analgesics. The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.

Surgery. In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or Questions

Please ask your Doctor of Chiropractic. We at Blau Family Chiropractic's have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of Chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Date

Signature of Patient or Parent

Printed Patient Name