preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

_____

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:
I give permission for the below named minor patient to be managed by the doctor when I am or when I am not present to observe such care.

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient:

_____
Signature: _____
Relationship to Patient: _____

Get *Moving* Chiropractic

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the

Get Moving Chiropractic Dr. Katy R. Mooberry DC, CACCP

30772 Southview Dr. #140 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

Financial and HIPPA Policies

***Please read the following carefully and initial each statement on the line provided.**

_____**Financial Policy and Agreement:**

Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a $30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you join the ChiroHealth USA (CHUSA) program (ask for more details). If you have insurance that pays for chiropractic care, we will be glad to verify benefits and bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need financial assistance or need to make special arrangements please talk with us.

_____ **I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable.** I will be responsible for any costs of collections, attorney's fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account. Insurance is billed by code; payment varies by plan.

_____ **Notice of Privacy Practices Acknowledgement:**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practice. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at ant time to obtain a current copy of the Notice of Privacy Practices.

_____ I UNDERSTAND THERE IS 24 HOUR CANCELLATION NOTICE, OR I WILL BE CHARGED THE COST OF THE VISIT.

I have read all of the above agreements and I accept these terms and conditions.

_____ _____

Patient signature or Guardian if patient is under 18 years of age Date

Patient Name _____ Date _____

Childhood History

Going back to your Elementary School days, did you:

- Play any organized sports? (If so, which sport, what position and how long?) _____

  _____

  _____

- Have any slips or falls landing on your tailbone? _____

  _____

- Use a backpack? ❑ Yes or ❑ No If yes, which side was dominant? Right / Left / Bilateral
- Have a minor car accident? ❑ Yes or ❑ No _____

  _____

- Approximately how many hours a day did you collectively watch TV, play video games, use a computer etc? 1-2 hours / 2-4 hours / 5 or more hours
- Get hit in the head with a bat or ball or did you play a contact sport? _____

  _____

- Fall from swings, slide, monkey bars or any high places? _____

  _____

As a young child, under the age of 5, did you:

❑ Fall in baby walker	❑ Fall from bed or couch	❑ Fall/bump on chin or tailbone
❑ Fall from crib	❑ Fall off swing	❑ Fall off bicycle
❑ Fall from highchair	❑ Fall off slide	❑ Fall down stairs
❑ Fall from changing table	❑ Fall off monkey bars	❑ Other _____

Pregnancy _____

_____

Delivery/Birth _____

_____

General

How do you sleep? Back / Side / Stomach Do you wake up? Rested / Tired / Unsure

As a child, how did you sleep? Back / Side / Stomach

Approximately how many hours a day do you sit? 1-2 hours / 2-4 hours / 5 or more hours

How old is your mattress? 0-2 years / 2-4 years / 4-6 years / 6-8 years / older

On a scale of 1 to 10, what would you rate your general stress level? _____

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PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

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

Has this child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

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PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME:_____ MOTHER'S NAME:_____ DOB:_____

CASE NUMBER:_____ FATHER'S NAME:_____ DOB:_____

ADDRESS:_____ CITY/TOWN:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOTHER'S WORK PHONE:_____ MOTHER'S CELL PHONE:_____

EMAIL:_____ FATHER'S WORK PHONE:_____ FATHER'S CELL PHONE:_____

BIRTH DATE:_____ _____ _____ AGE:_____ SEX:_____ NUMBER OF SIBLINGS:_____ REFERRED BY:_____

BIRTH WEIGHT:_____ BIRTH LENGTH:_____ CURRENT WEIGHT:_____ CURRENT LENGTH:_____

THIRD TRIMESTER PRESENTATION: VERTEX_____ BREECH_____ TRANSVERSE_____ FACE/BROW_____

TYPE OF BIRTH: NORMAL VAGINAL_____ FORCEPS_____ CESAREAN_____ SUCTION CAP OR VACUUM_____

LOCATION: HOME_____ BIRTHING CENTER_____ HOSPITAL_____

PROBLEMS DURING PREGNANCY:_____

PROBLEMS DURING LABOR/DELIVERY:_____

APGAR SCORES:_____ _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? _____ CYANOSIS (BLUE)? _____

CONGENITAL ANOMALIES/DEFECTS?_____ IF YES, PLEASE EXPLAIN?_____

INFANT FEEDING: BREAST_____ BOTTLE_____ IF BOTTLE, WHICH FORMULA? _____

NUMBER OF HOURS SLEEPING PER NIGHT:_____ QUALITY OF SLEEP: GOOD_____ FAIR_____ POOR _____

OBSTETRICIAN/MIDWIFE:_____

PEDIATRICIAN/FAMILY MD:_____

DATE OF LAST VISIT:_____ _____ _____ PURPOSE:_____

IMMUNIZATION HISTORY:_____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS_____ DURING HIS/HER LIFETIME_____

PREVIOUS CHIROPRACTOR:_____

DATE OF LAST VISIT:_____ _____ _____ PURPOSE:_____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS?_____ IF YES, PLEASE EXPLAIN:_____

PURPOSE OF THIS APPOINTMENT:_____

INSURANCE/BILLING INFORMATION:_____ POLICY #:_____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED. X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED:_____ DATE_____ _____ _____

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