WELCOME TO RĀDIX CHIROPRACTIC

CHILD APPLICATION

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

Cell Phone: _____ Alternate Phone: _____

Text Reminders: Y N Before Visit: 1hr 4hrs 1 day Email Address: _____

(for updates on office hours, events, etc.)

Birth Date: _____ Age: _____

# of Siblings: _____ Sibling's Names: _____

Parent's Names: _____

Best Contact: _____ Alternate Contact: _____

Who can we thank for referring you/how did you hear about Rādix Chiropractic? _____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Relation: _____

REASON FOR SEEKING CARE

What is your primary reason for bringing your child to our office today? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply) _____

_____

Have you seen any other providers for this condition? (List all that apply) _____

_____

CHIROPRACTIC HISTORY

Has your child ever had a spinal examination by a Chiropractor? ☐ Yes ☐ No If yes, Doctor Name: _____

Date of Last Chiropractic Visit: _____ Reason for Care: _____

Date of Last Chiropractic X-Rays: _____ How long were you under care? _____

Are other family members under chiropractic care? ☐ Yes ☐ No Who? _____

COMMITMENT TO HEALTH

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health.

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

What health goal, if you were to complete or accomplish it, would have the greatest impact on your child's life? _____

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Fatigue/Sleep Issues
- ☐ Digestive Troubles
- ☐ Bed Wetting
- ☐ Nausea/Vomiting
- ☐ Overweight
- ☐ Diabetes
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Loss of Concentration
- ☐ Developmental Delay
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Headaches
- ☐ Neck/Back Pain
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Sinus Troubles/Allergies
- ☐ Learning Disorders
- ☐ Autism/Asperger's/Sensory Issues
- ☐ Others _____

Explain any boxes checked above or add additional concerns:

Is there anything else regarding your current condition you feel the doctor should know?

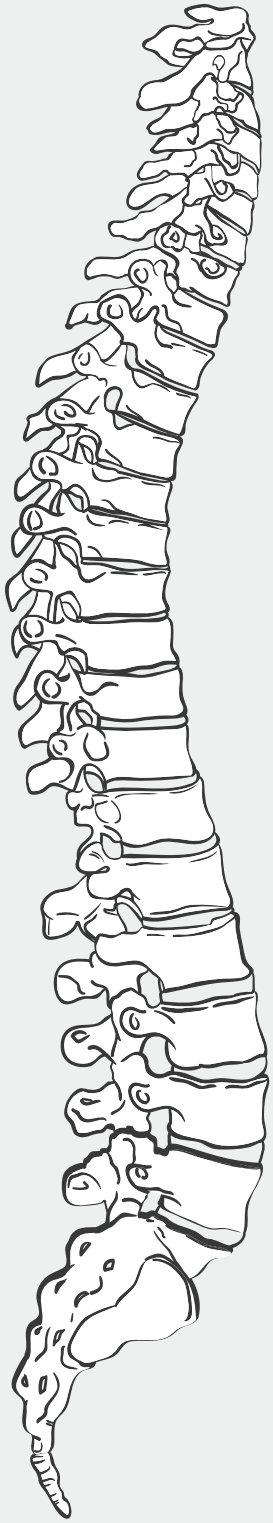
MEDICATIONS/SUPPLEMENTS

- ☐ Anxiety/Depression
- ☐ Migraine/Headache
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Pain Narcotics
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Muscle Relaxers
- ☐ Others _____
- ☐ Supplements _____
- ☐ Supplements _____

Explain any boxes checked above or add additional concerns:

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



Headaches Migraines
Dizziness
Sinus Problems Allergies
Fatigue Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems
Asthma
Allergies
High Blood Pressure
Neck Pain
Arm Pain

Middle Back Pain
Congestion Difficulty
Breathing Bronchitis
Pneumonia Gallbladder
Conditions Stomach
Problems Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation Colitis
Diarrhea
Gas Pain
Irritable Bowel Bladder
Problems Low Back
Pain Pain in legs
Reproductive Problems

PRENATAL HISTORY

Location of Birth: Home Birthing Center Hospital Other: _____

Did any of the following happen during delivery?

- ☐ C-section delivery
- ☐ Labor was induced
- ☐ Premature delivery
- ☐ Special medical procedures/tests
- ☐ Doctor pulled or twisted baby
- ☐ Forceps/vacuum extraction
- ☐ Anesthesia

Describe any of the above, plus any additional complications experienced during delivery: _____

_____

_____

During pregnancy, did you experience any illness, complications and/or concerns? If yes, please explain: _____

_____

Birth weight: _____ Birth length: _____ APGAR scores: _____

Ultrasound used during pregnancy? ☐ Yes ☐ No Number of times: _____

Did / do you breastfeed the baby? ☐ Yes ☐ No If yes, how long: _____

Did / do you formula-feed the baby? ☐ Yes ☐ No If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child... Exercise daily? ☐ Yes ☐ No How much? _____

Have a positive self-esteem or self-image? ☐ Yes ☐ No

Play video games or watch TV for more than one hour per day? ☐ Yes ☐ No How much? _____

Eat balanced meals? ☐ Yes ☐ No

Experience prolonged sadness? ☐ Yes ☐ No Explain: _____

Have difficulty sleeping? ☐ Yes ☐ No Explain: _____

CHILD'S HEALTH & INJURY HISTORY

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No Explain: _____

_____

Does your child have difficulty interacting with others? ☐ Yes ☐ No Explain: _____

_____

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

☐ Yes ☐ No Explain: _____

Has your child ever been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?

☐ Yes ☐ No Please list: _____

Are you aware of any food allergies or intolerance? ☐ Yes ☐ No Explain: _____

Has your child received all recommended vaccinations? ☐ Yes ☐ No Explain: _____

Please rate stress levels on a scale of 1-10 (10 being the highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? ☐ Yes ☐ No

If yes, please explain how/when: _____

Has your child been diagnosed with any disease(s)/health condition(s) by a doctor? ☐ Yes ☐ No

If yes, please explain how/when: _____

Is there anything else you would like us to know about your child before we see him/her? _____

_____

X-RAY AUTHORIZATION FORM

X-RAY AUTHORIZATION AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONISBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. **THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.**

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT DURING REGULAR OPERATING HOURS. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF RĀDIX CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, THEY WILL BE BROUGHT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

Print Name: _____ Date: _____

Signature: _____ Age: _____

Introduction to the Office

Thank you again for choosing Radix Chiropractic. We want to assure you that we will provide you with the optimum in chiropractic care and recommendations in the most professional and honest manner.

To begin this process, here are a few important methods and terms as you begin care:

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method 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 vertebrae 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 and performance.

On your first visit we will gather information about your through our Initial Consultation and Chiropractic Analysis (Spinal Exam and X-Rays). You will then receive your first specific chiropractic adjustment.

Once the analysis is complete and your subluxations (if any) have been corrected, we will schedule your second visit which will be your Chiropractic Report. At that visit, you will be educated and shown your x-rays. You will then be given your second adjustment and presented with our recommendations for your care. This will require some basic knowledge that may be new to you even if you have been to chiropractors in the past. Remember, our findings are strictly chiropractic in nature and do not involve any other areas of your health.

REASON FOR CONSULTING THIS OFFICE

(Please check one of the following three reasons)

_____ I have no specific complaints; I understand the role of chiropractic in my general well-being.

_____ I have the symptom of a physical problem and I want to see if chiropractic will enable my body to work better. I am also interested in learning about the role of chiropractic in improving my overall performance and that of my family.

_____ I have a symptom and I am only interested in patch-up care for it.

Again, welcome to our office. We look forward to a long, healthy relationship with you!

Terms of Acceptance

When a person seeks the services of a chiropractor, it is essential that they fully understand the objectives of that particular chiropractor. It is important that each person understands both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment.

We have one goal at Radix Chiropractic; To restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine), which interfere with the function of these nerve pathways, are called **vertebral subluxations**. Subluxations are caused by many of the things you do **everyday** and keep your **whole** body from functioning properly. It is our absolute conviction that the **body is always better off without this interference.**

Consequently, the objective of Radix Chiropractic is to locate, analyze and bring about the correction of **Vertebral Subluxation** through a specific chiropractic adjustment thereby restoring normal nerve function. It is not the objective or intention of Radix Chiropractic to diagnose, treat or cure any disease nor do we offer advice about any ailments or treatment prescribed by others. **With a proper nerve supply your whole body is better able to reach its full potential and to express more life.**

Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate intelligence and ability to heal and perform at its God-given potential.

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

All questions regarding the Chiropractors objective pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

PREGNANCY RELEASE

☐ **Yes**: I am pregnant and choose NOT to receive any X-rays.

☐ **No**: I state that to my knowledge, I am not pregnant, nor do I have any reason to believe that I may be pregnant. I give permission to the doctor and his staff to perform X-ray(s). Date of last menstrual period_____.

INFORMED CONSENT

Radix Chiropractic

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www.radixchiro.com

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 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 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, and radiological examination (x-rays).

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. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, 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 adjustments may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors.

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Research and scientific evidence do not establish a cause-and-effect relationship between chiropractic adjustments 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 care has 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.

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 RYAN BETZ, D.C. TO PROCEED WITH CHIROPRACTIC CARE.

PATIENT FULL NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

CONSENT TO CARE OF MINOR CHILD

I hereby authorize, Radix Chiropractic's Doctors of Chiropractic to administer Chiropractic Care as they deem necessary to my child.

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Child Name: _____

Date of Birth: _____

Printed name of person legally authorized to sign for minor;

Parent/Guardian: _____

Signature: _____

Relationship to Patient: _____

Date: _____

PATIENT PRIVACY ACKNOWLEDGEMENT

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care relationship, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the "Notice of Privacy Practices" document that is available to you on our website as well as at the front desk before signing this consent.

1. The patient understands and agrees to allow Rādix Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Rādix Chiropractic and its' employees to submit requested PHI to the health insurance company (ies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company (ies) require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Rādix Chiropractic has the right to refuse to give care.

I have read the Privacy Notice and understand how my Protected Health Information will be used and I agree to these policies and procedures. I acknowledge that I will receive access to my health records and allow Rādix Chiropractic to release all medical records to me.

Patient Name: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

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