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**New Patient Children Ages 3 - 12**

First Name: Middle Initial: Last Name: Age: \_\_\_\_\_\_\_ Gender: M F

Home Address: Home Phone: ( )

City, State, Zip: Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_

Mothers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fathers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition start? \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does the pain radiate into your: \_\_\_Arm \_\_\_Leg If yes: \_\_\_ Right \_\_\_ Left

Type of pain: Sharp Dull Ache Burn Throbbing Spasm Tingling Shooting

Circle intensity of pain below:

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Discomforting Distressing Horrible Excruciating

What activities aggravate your symptoms? \_\_\_\_\_\_\_

Is there anything, which has relieved your symptoms? Yes No Describe:

Does complaint(s) interfere with: \_\_Work \_\_Sleep \_\_Hobbies \_\_Daily Routine Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced this condition before? Yes No If so, please explain: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who have you seen for this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CERVICAL SPINE (NECK):

Problems in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience?

* Neck Pain
* Pain into your shoulders/arms/hands
* Numbness/tingling in arms/hands
* Hearing disturbances
* Weakness in grip
* Headaches
* Dizziness
* Visual disturbances
* Ear infections
* Coldness in hands
* Thyroid conditions
* Sinusitis
* Behavioral (ADHD/ADD/Autism/Asperger’s/General Hyperactivity) Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Allergies/Hay fever
* Recurrent colds/Flu
* Low Energy/Fatigue
* TMJ/Pain/Clicking

THORACIC SPINE (UPPER & MID BACK):

Problems in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience?

* Heart Palpitations
* Heart Murmurs
* Tachycardia
* Heart Attacks/Angina
* Recurrent Lung Infections/Bronchitis
* Asthma/Wheezing
* Shortness Of Breath
* Pain On Deep Inspiration/Expiration
* Mid Back Pain
* Pain into Ribs & Chest
* Indigestion/Heartburn
* Nausea
* Ulcers/Gastritis
* Tired/Irritable

LUMBAR SPINE (LOW BACK):

Problems in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience?

* Muscle cramps in your legs/feet
* Constipation / Diarrhea
* Weakness/injuries in your hips/knees/ankles
* Recurrent bladder infections
* Frequent/difficulty urinating
* Menstrual irregularities/cramping (females)
* Bedwetting
* Toes/Feet inward or outward/Bowed Legs
* Low back pain
* Coldness into legs/feet
* Pain into legs/feet
* Tingling into legs/feet

Please list any health conditions not mentioned:

Please list any medications currently taking and their purpose:

Do you take any supplements (i.e. vitamins, minerals, herbs)?

Please list all past surgeries:

Please list all previous accidents and falls:

Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MINOR / CHILD CONSENT FORM

I am the parent, guardian, or personal representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print name of minor)

And there are no court orders now in effect that prohibit me from signing this consent.

I do hereby request and authorize the doctor and practice staff necessary services for the child

named above, which are deemed advisable by the doctor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ \_\_\_

Signature of, Parent, Guardian or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ \_\_\_\_

Please print name of Parent, Guardian or Personal Representative

**AUTHORIZATION FOR CARE**

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Darlington Chiropractic Clinic, LLC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Darlington Chiropractic Clinic will be credited to my account on receipt.

We make recommendations based on what you need and your health goals and not on what your insurance coverage is. Your insurance company makes the final determination on whether a service is medically necessary and will be covered by insurance.

Darlington Chiropractic Clinic, LLC. has advised me that:

1. Many insurance companies permit collection of payment for services directly from the patient if the patient requests the services and if the patient is informed in advance that the services are not covered or may be denied as not medically necessary; and
2. It is the patient’s financial responsibility to pay for these services.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that Darlington Chiropractic Clinic may verify such coverage as a courtesy to me, but that Darlington Chiropractic Clinic cannot be held responsible or liable for inaccurate information provided to it by my insurance carrier.

Patient Guardian Signature Date

**NOTICE OF PRIVACY POLICY**

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

* You may request restrictions on your disclosures
* You may inspect and receive copies of your records for a fee within 14 days with a request.
* You may request to view changes to your records.
* In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician’s certifications. have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print)

Patient Guardian Signature Date

Office Staff: Date

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

* Carrie M. Shippy, D.C.
* OR The licensed chiropractors filling in at Darlington Chiropractic Clinic, LLC

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Printed of Guardian/Parental and Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Parental Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

Office Representative Name Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Office Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_