



Thank you for choosing our clinic for your chiropractic care. Please complete this form **in ink**.

**We are happy to help you---just ask!**

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth (D.O.B.) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: **M** **F**

Home Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Height: \_\_\_\_ft. \_\_\_\_in. Weight: \_\_\_\_\_lbs.

Email: \_\_\_\_\_ **\*Who may we thank for referring you?** \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Preferred places for messages? **Home Cell Work Email** (Circle all that apply)

Marital Status:  Married  Single  Divorced  Widowed Spouse's name: \_\_\_\_\_

Women: Is there a chance you are pregnant? \_\_\_\_\_ Due date? \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Your employer: \_\_\_\_\_ Job title: \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Doctor (PCP)** \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had previous chiropractic care? No Yes Date of last care: \_\_\_\_\_

Is this an accident case? Yes No Date of accident: \_\_\_\_\_

Circumstances: Auto collision On the job Other \_\_\_\_\_

Details: \_\_\_\_\_

**Staff only:** BP \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_

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Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance:

Insurance Company Name \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Group # \_\_\_\_\_ Contract # \_\_\_\_\_

Patient's Relationship to subscriber (Circle one):    Self    Spouse    Child    Dependent

\_\_\_\_\_ I authorize BCC to copy my driver's license/personal I.D. --and insurance cards, if applicable--for my records

Financial Responsibility With/Without Insurance: All services rendered to me are charged directly to me; I am personally and financially responsible for payment of all charges incurred at Brusveen Chiropractic Clinic & Therapy, PLC ("BCC" or, "BCC, PLC"), including insurance deductibles, copayments, and any & all services rejected/not covered by insurance. All charges are due at the time of service unless I have signed a payment plan agreement. I instruct and direct my insurance company to pay, by check made out to and mailed directly to BCC, PLC, the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward charges for professional services rendered by BCC, PLC; a photocopy of this assignment shall be considered as valid as the original. I authorize BCC, PLC to release any pertinent Protected Health Information (PHI) to any insurance company, adjustor, and/or attorney involved in my case, and I hereby release BCC, PLC of any consequence thereof.

Health and accident insurance policies are an arrangement between the insurance carrier and me; I am responsible for knowing my carrier's rules, regulations, and payment policies. For specific questions regarding my insurance coverage, I must contact my carrier directly. **As a courtesy**, BCC will submit insurance bills within 4 weeks of date of service; BCC has no control over insurance carriers' response time(s). As BCC will collect approximated amounts from me, I may end up with a bill or credit on my account. For any automobile accident claim(s), I am responsible for any charges rejected, deemed unreasonable or unnecessary by my automobile insurance company and/or an independent medical examination, and BCC may require another form of payment guaranty. If workman's compensation is deemed unrelated to work, I will be responsible for all services.

Delinquent accounts (over 60 days of non-payment by patient and/or insurance) will be assessed a \$25 billing charge. An additional \$75.00 minimum amount will be charged if outside collection agency and/or small claims court are required to collect the balance on an account. I agree to resolve all financial matters with BCC on my own, without legal representation.

Chiropractic, like medicine, is an applied science as well as an art; absolute guarantees are not possible. I understand that regardless of individual results, I am responsible for payment for services received at BCC. If I suspend or terminate my recommended treatment of care, any fees for professional services will be immediately due and payable.

***There is a 0.0399% surcharge for using credit/debit cards.***

**Health Insurance Portability and Accountability Act (HIPAA):** BCC's current Notice of Privacy Practices (NOPP) has been made available to me. The NOPP explains my rights and BCC's duties regarding my PHI, including ways in which my PHI may be used or disclosed by BCC. BCC reserves the right to amend its NOPP. A printed copy of BCC's current NOPP is provided upon request at BCC's main administrative desk, or by calling BCC and asking that a copy be mailed to me.

**These people are authorized to receive my health and financial information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**I understand and agree to all the above financial responsibility/HIPAA terms and conditions:**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_



## Pediatric Health History Form (Age 10 & under)

It is a pleasure to welcome you to our family of healthy chiropractic patients. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Names of Parents/Guardians: \_\_\_\_\_

Purpose for visit: \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_ No \_\_\_\_ Yes

Name of Pediatrician: \_\_\_\_\_

Other Health Problems: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Check any of the following conditions your child has suffered during the past six months:

- |   |   |                                  |  |  |
|---|---|----------------------------------|--|--|
| <input type="checkbox"/> Ear Infections   | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizure | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Colic   | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Car accident    |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing back pains | <input type="checkbox"/> ADHD    | <input type="checkbox"/> Bed Wetting   |  |
| <input type="checkbox"/> Others: _____    |   |                                  |  |  |

Family Health History:

\_\_\_\_\_

# of doses of antibiotics child has taken in the past six months: \_\_\_\_\_ Total during lifetime: \_\_\_\_\_

# of doses of other prescription medications your child has taken in the past six months: \_\_\_\_\_

List of medications: \_\_\_\_\_ Total during lifetime: \_\_\_\_\_

Did you choose to have your child vaccinated? \_\_\_\_ No \_\_\_\_ Yes

History: \_\_\_\_\_

Have you noticed any side effects of changes post-vaccination? \_\_\_\_\_

### CHILDHOOD DISEASES

Chicken pox: \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_ Mumps \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_

Rubella: \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_ Whooping Cough \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_

Rubeola: \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_ Other \_\_\_\_\_ \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_

Menarche (first menstrual period) \_\_\_\_ No \_\_\_\_ Yes Age: \_\_\_\_\_

Brusveen Chiropractic Clinic & Therapy, PLC

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRENATAL HISTORY**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Ultrasound during pregnancy? \_\_\_ No \_\_\_ Yes Number: \_\_\_\_\_

Medications during pregnancy? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy: \_\_\_ No \_\_\_ Yes

Location of birth: \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Home

Birth Intervention: Forceps, Vacuum Extraction, Caesarean Section, Emergency or Planned? \_\_\_\_\_

Complications during delivery: \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Genetic Disorders or Disabilities: \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

**FEEDING HISTORY**

Breast Fed: \_\_\_ No \_\_\_ Yes How Long: \_\_\_\_\_

Formula Fed: \_\_\_ No \_\_\_ Yes How Long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced Solids at \_\_\_\_\_ Months Cow's Milk at \_\_\_\_\_ months

Food/Juice allergies or Intolerances: \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spine & interference).

At what age was your child able to:

Respond to Sound \_\_\_\_\_ Respond to Visual Stimuli \_\_\_\_\_ Hold Head Up \_\_\_\_\_

Sit Up \_\_\_\_\_ Cross Crawl \_\_\_\_\_ Stand Alone \_\_\_\_\_ Walk Alone \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place their first year of life (i.e. a bed, changing table, down stairs, etc). Was this the case with your child? \_\_\_ No \_\_\_ Yes

List: \_\_\_\_\_

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, etc.)? \_\_\_ No \_\_\_ Yes

List: \_\_\_\_\_

Has your child ever been involved in a car accident? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Has your child been seen on an emergency basis? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Other traumas not described above? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Prior Surgery? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Brusveen Chiropractic Clinic & Therapy, PLC

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

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

Major Complaint \_\_\_\_\_

The major complaint came on gradually (how long) \_\_\_\_\_ suddenly (date of onset) \_\_\_\_\_

What makes the condition worse? Cough Laugh Sneeze Bend/Lift Stand Sit Walk

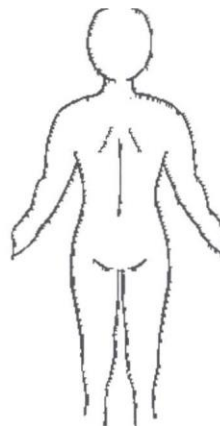
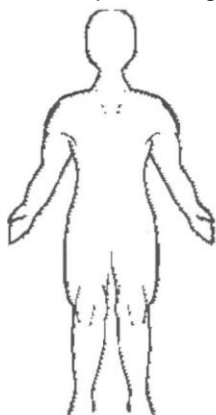
What makes the pain better? Sit Stand Lie Down Meds Heat Ice Other \_\_\_\_\_

When is the pain worse? Morning Afternoon Evening Night All the time Varies

When is the pain better? Morning Afternoon Evening Night All the time Varies

Description of pain: Burning Tight/Stiff Dull Tingling Ache Sharp Other Throbbing Spasm Radiating Numbness

Please draw where you are experiencing symptoms.



Has this condition happened before? Yes NO If yes, when \_\_\_\_\_

What diagnostic tests have you had for this condition? \_\_\_\_\_

Is this condition interfering with your: Work Sleep School Daily Routine Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

**CONSENT TO TREAT MINOR:**

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results!

I hereby authorize this office and its doctors to administer care to my son/daughter, as they deem necessary, even if I am not present.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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