Welcome to
Community Chiropractic of Acton

Today's Date _____

Personal Data

Name _____ Date of Birth _____ Gender M F T

Home Phone (_____)_____ Email Address _____

Home Address _____ City _____ State ____ ZIP _____

Name of Parent(s)/Guardian(s) _____

Whom may we thank for referring you to our office? _____

Reasons for Seeking Chiropractic Care

What concerns do you feel our office can address for your child?

_____

_____

Have you seen other Doctors for this condition? Y N

If yes, with whom and treatments _____

Other health concerns? _____

Circle any of the following conditions that your child has suffered from within the past six months:

Ear Infection	Growing / Back Pains	Seizures	Chronic Colds	Headaches
Asthma / Allergies	Digestive Problems	ADHD	Recurring Fevers	Colic
Bed Wetting	Car Accident	Temper Tantrums	Other_____	

Other Data

Has your child ever received Chiropractic Care? Y N With whom? _____

Date of last visit: _____ Why did you stop care? _____

Name of child's Pediatrician_____ Date of last visit _____

Number of doses of Antibiotics your child has taken:

During the past six months: _____ Total during his/her lifetime: _____

Reasons for taking antibiotics _____

Has your child been vaccinated? Y N

Prenatal History

Name of Obstetrician/Midwife:_____

Complications During Pregnancy? Y N

If yes, what were they? _____

Ultrasounds During Pregnancy? Y N If yes, number: _____

Medications During Pregnancy/Delivery? Y N If yes, what? _____

Cigarette/Alcohol Use During Pregnancy? Y N

Location of Birth (Circle one) Hospital Birthing Center Home

Birth Intervention(Circle all that apply)

Forceps Vacuum Extraction Cesarean Section(Emergency or Planned)

Complications During Delivery? Y N

If yes, what were they? _____

Genetic Disorders or Disabilities: Y N If yes, list:_____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breastfed: Y N How Long: _____

Formula Fed: Y N How Long: _____

Introduced to Solids at: _____ Months, Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: Y N

If 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 (spinal nerve 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 during their first year of life (i.e., a bed, changing table, down stairs, etc.).

Was this the case with your child? Y N

Is/has your child been involved in any high impact or contact type sport (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Y N

If yes, list: _____

Has your child ever been involved in a Car Accident ? Y N

If yes, list: _____

Has your child been seen on an Emergency Basis ? Y N

If yes, list: _____

Other Traumas Not Described Above? Y N

If yes, list: _____

Prior Surgery? Y N

If yes, list: _____

Menarche? Y N If yes, age? _____

Childhood Diseases (circle all that apply)

Chicken Pox - Age _____ Mumps - Age _____ Rubella - Age _____

Measles - Age _____ Whooping Cough - Age _____ Other _____

Financial Information

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

The cash fee for a new patient is $200.00, which includes the first consult, a chiropractic exam, a computerized posture analysis, x-rays if necessary, a report of findings, and the first adjustment

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the “Insurance Permission” section below.

Signature _____ Today’s Date _____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

“I authorize Community Chiropractic of Acton to release to my insurance company any medical or other information necessary to process my insurance claims. I authorize payment to be made directly to Community Chiropractic of Acton. I permit a copy of this authorization to be used in place of the original.”

Signature: _____ Date _____

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber’s name: _____ Subscriber’s date of birth: _____

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Community Chiropractic of Acton to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience at Community Chiropractic of Acton.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Community Chiropractic of Acton. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Community Chiropractic of Acton are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required, if asked, to supply you with a copy of our privacy policies and procedures. If you would like to read this document, please ask our front desk staff. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I am able to receive and review a copy of Community Chiropractic of Acton Notice of Privacy Practices for Protected Health Information. Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____	_____	_____
Patient name printed	Patient Signature	Date

Terms and Consent to Care

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. 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.

The objective of chiropractic health care in this office is to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations. 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.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

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 healthcare 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.

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

I therefore accept chiropractic care on this basis.

_____ _____

Patient Signature Date

Credit Card Authorization

Name: _____ Date: _____

Last First Middle Initial

I,_____, give authorization for Community Chiropractic of Acton to charge my credit card for any and all services rendered to me. I acknowledge that I am legally responsible for any and all charges and I authorize my credit card to be charged the total of any back balance if I decide to discontinue my care.

( ) MasterCard ( ) Visa ( ) Discover ( ) AMEX ( ) FSA/HSA

Credit Card Number:_____

Expiration Date:_____ Security Code(3 digits):_____

Address of Credit Card:_____ Zip Code: _____

Signature: _____ Date: _____

Our purpose is to educate and adjust families toward optimal health with natural chiropractic care.