FAMILY CHIROPRACTIC

Pediatric History Form

Date:_____

Patient Name_____ SS#_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Cell Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care:_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness
_ADHD
_Backaches
_Heart Condition
_Chronic Earaches
_Diabetes
_Tuberculosis
_Hypertension
_Fever/Chills
_Frequent Colds
_Arthritis
_Headaches
_Asthma
_Allergies
_Runny Nose
_Itchy Eyes
_Rashes

_Unusual Moles
_Neuritis
_Digestive
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Constipation
_Anemia
_Rheumatic Fever
_Diarrhea
_Poor Appetite
_Hyperactivity
_Behavioral
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting

_Pain Urinating
_Convulsions
_Paralysis
_Muscle Pain
_Fainting
_Broken bones
_Sprains/Strains
_Hernias
_Neck Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain
_Scoliosis
_Blood disorders
_Stomach Aches
_Other _____

Health History:

Name of Pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? **Y/N** Condition treated: _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) **Y/N**
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? **Y/N** Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) **Y/N** _____
Other traumas not described above? **Y/N** Type & Date: _____
Prior surgery: **Y/N** Type and Date:_____ Menarche: **Y/N** Age:_____

Prenatal History

Location of Birth: _Home _Birthing Center _Hospital Not the Birth Parent? _Stepchild _Adopted
Complications during pregnancy: **Y/N** List: _____
Ultrasounds during pregnancy: **Y/N** Number: _____
Medications during pregnancy/delivery: **Y/N** List: _____
Cigarette / Alcohol use during pregnancy: **Y/N**
Birth intervention: _Forceps _Vacuum _Caesarian, Why?_____
Complications during delivery: **Y/N** List: _____
Genetic disorders or disabilities: **Y/N** List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history

Breast Fed: **Y/N** How long?_____ Formula fed: **Y/N** How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances **Y/N** List: _____

Developmental History

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl ___ Sit alone ___ Stand alone ___ Walk alone ___ Say words ___

Childhood Diseases

_Chicken Pox - Age ___ _Mumps - Age ___ _Rubella - Age ___ _Whooping cough - Age ___
_Measles - Age ___ _Meningitis - Age ___ _Tuberculosis - Age ___ *Other*_____ - Age ___

Vaccination History:

_None _MMR (Measles, Mumps, Rubella) – Age ___
_HBV / Hep B (Hepatitis B) – Age ___ _Varicella (Chicken Pox) – Age ___
_DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age ___ _PCV (Pneumoccocal) – Age ___
_HbCV / Hib (H. influenzae type b conjugate) – Age ___
_OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age ___
Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance

Do you have medical insurance? Y/N Insurance Company Name _____
Policy Number _____ Insurance Company Phone number _____
Insured's Name _____Relationship to patient _____
Insured's DOB _____ Insured's SS# _____
Insured's Employer _____ Insured's Employee Address_____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____
hereby grant permission for my child to receive chiropractic care.

Signed _____ Date _____

Witnessed _____ Date _____

FAMILY CHIROPRACTIC

Family Chiropractic Fee Schedule

Examination $50 - May be submitted to an Insurance Company for reimbursement.
Adjustment $42 - May be submitted to an Insurance Company for reimbursement.
Child/Student Discount Adjustment $25 - May NOT be submitted to an Ins. Co.
1st Additional Family Member Adjustment $25 - May NOT be submitted to an Ins. Co.
2nd or More Additional Family Members $10 - May NOT be submitted to an Ins. Co.

PRE- PAYMENT PLAN 10 visits $350
Normal cost $420 = savings of $70 / Over 16% savings
Must be paid in full & may not be submitted to insurance company for reimbursement.

A MONTH of Care $255
This is a CASH UP FRONT Discount for Intensive Care (12 visits. 12 x $42 = $504; **SAVINGS of $249!!).** This plan is designed for practice members who are serious about their commitment to being well. You must attend a 'Wellness Class' in order to qualify for this program. This MUST be PAID IN FULL, at the BEGINNING of each month, and MAY NOT be submitted to an Insurance Company. If you wish to submit your bills to an insurance company for reimbursement, you must pay the FULL adjustment amount $42 at the time of each service, then we would be happy to bill your company for you, as a courtesy.

A YEAR of Care $2550
This is a CASH UP FRONT Discount for Intensive Care (144 visits. 144 x $42 = $6048; **SAVINGS of $3,498!!** At 144 visits a year, 3X per week, that averages to **$17.70 a visit!!**). This plan is designed for practice members who are serious about their commitment to being well. You must attend a 'Wellness Class' in order to qualify for this program. This MUST be PAID IN FULL, at the BEGINNING of your year, and MAY NOT be submitted to an Insurance Company. If you wish to submit your bills to an insurance company for reimbursement, you must pay the FULL adjustment amount $42 at the time of each service, then we would be happy to bill your company for you, as a courtesy.

Our mission is to motivate you, encourage you, and move you & your family members toward greater levels of well-being.
Our Goal is to provide you with excellent care, outstanding service and fees that will allow you to receive the FULL benefit of chiropractic care. Chiropractic is an important part of the equation for good health.
Please feel free to discuss any questions or concerns regarding you finances with our office assistants. They are prepared and authorized to work with you to find the payment plan designed for your needs.
The Family Chiropractic Fee Schedule has bee thoroughly explained to me, I understand that I may ask to review these options at any time. If I have chosen a CASH UP FRONT or other DISCOUNTED option, and I wish to discontinue care before I reach the allotted number of visits, I will be refunded the balance in full minus $42 for each of the visits I used.

Signature _____ Date _____

Witness _____ Date _____

Dr. John Przybylak • Dr. Jessica D'Amore
Family Chiropractic • 4017 Harlem Road • Snyder, NY 14226 • 716.839.5100

FAMILY CHIROPRACTIC

Terms of Acceptance

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of focus to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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.

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 examination, 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 health care 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. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a **minor child**

I, _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(Signature) (date)

FAMILY CHIROPRACTIC

Acceptance of Responsibility

I, the undersigned, accept responsibility for any bills that I incur. If for any reason my insurance does not cover these expenses, I understand that I will be solely responsible. If my Insurance coverage includes a co-payment, I will also be responsible for the amount of each co-payment.

_____ _____

Signature Date