ABOUT THE PATIENT

Child's Name _____ **Today's Date** _____ **Birthdate** _____ **Age** _____ **Gender** M F

Child's School _____ **Grade** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Parent / Guardian 1

Name _____

Relationship _____ **Cell** _____

Email _____

Employer (optional) _____

Parent / Guardian 2

Name _____

Relationship _____ **Cell** _____

Email _____

Employer (optional) _____

Have you been to a chiropractor before? No Yes **When was your last Chiropractic Appointment?** _____

Who Referred you to us? _____

Emergency Contact _____ **Ph #** _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- I understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.

_____ _____

Parent / Guardian Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____ Pain radiates to _____

Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same
Getting worse Mild Moderate Severe Worse in the morning Worse in evening

2. _____ How long has this been an issue? _____ Pain radiates to _____

Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same
Getting worse Mild Moderate Severe Worse in the morning Worse in evening

3. _____ How long has this been an issue? _____ Pain radiates to _____

Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same
Getting worse Mild Moderate Severe Worse in the morning Worse in evening

4. _____ How long has this been an issue? _____ Pain radiates to _____

Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same
Getting worse Mild Moderate Severe Worse in the morning Worse in evening

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctors have you seen for this? _____

_____

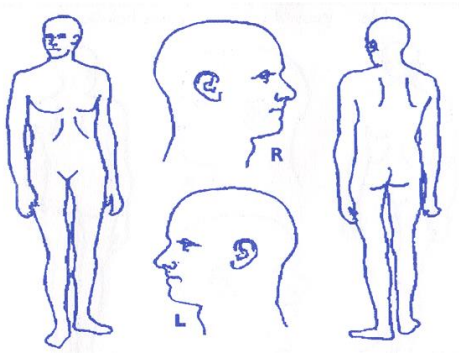
9. Type of treatment: _____

10. Results: _____

NOTES: _____

_____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Mark the conditions that apply to you.

Past	Present		Past	Present	
		Headaches			Vision Problems
		Ear Infections			Sleeping Problems
		Colic			Chronic Colds/Sinus
		Allergies / Asthma			Scoliosis
		Medication Side Effects			Temper Tantrums
		Recurring Fevers			ADHD/Spectrum Disorder
		Digestive problems			Seizures
		Bed Wetting			Delayed Developmental Milestones (trouble walking or crawling)
		Other _____			

1. Vaccinations: Up to date Delayed Schedule None

2. List any medications being taken: _____

3. Number of courses of Antibiotics child has taken in the last 6 mo. _____ **Total during lifetime** _____

4. Name of Pediatrician and Other Doctors: _____

5. Date of Last Visit ____ / ____ / _____ **Reason:** _____

6. Name of Obstetrician/Midwife (If under 5 y.o.) _____

7. Location of Birth: Hospital Birthing Center Home

8. Complications During Pregnancy or Delivery: No Yes

Explain: _____

9. Mode of Delivery: Vaginal Cesarean Forceps Vacuum

10. Was an induction performed: No Yes

11. Were any of the following received: Epidural Pain meds

12. Ultrasounds During Pregnancy: No Yes **How Many:** _____

13. Medication During Pregnancy No Yes **List:** _____

14. Cigarette / Alcohol Use during Pregnancy: No Yes

15. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor": No Yes, Name

_____

PAST HISTORY

16. List any past auto collisions: _____ **Was any care received?** _____

17. List any past falls bumps bruises: _____ **Was any care received?** _____

18. List any past sport, recreational, or home injuries: _____

19. Please describe any past conditions and treatment received: _____

_____

20. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Is there any other family history you want us to know? _____

_____

Paying for your care is easy here!

Initial which one is you:

No Insurance:

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like LASIK, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial _____

Health Insurance:

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial _____

Auto Injury

- Auto injuries: if you were not the at-fault driver, your care is typically covered by the at-fault driver's insurance.
- All we need is your claim number and insurance information.

Initial _____

Medicare

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial _____

You have made a great decision to get care here!
Our goal is to be your family chiropractor for life!

Informed Consent

Section 1: Informed Consent for Chiropractic Care

We are committed to providing you with safe, effective, and natural chiropractic care. Please read this form carefully.

What is Chiropractic Care? Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints to improve alignment, movement, and overall function.

What to Expect During Your Care:

- Thorough health history and physical exam (posture, movement, muscle strength, etc.).
- X-rays may be recommended.
- Personalized care plan that may include adjustments, soft tissue therapies, exercises, or referrals if needed.

Benefits of Chiropractic Care:

- Reduced pain or discomfort in back, neck, or joints
- Improved mobility, flexibility, and posture
- Enhanced overall wellness, energy, and physical performance

Understanding Rare Risks: Chiropractic care is very safe, but like any healthcare approach, there are rare risks:

- Temporary soreness or discomfort after adjustments
- In very rare cases, minor muscle or ligament strain
- Extremely rare risks involving neck adjustments (estimated at less than 1 in 1 million)

What Happens if You Choose Not to Pursue Care? You may continue to experience discomfort, limited mobility, or other symptoms. Untreated issues could worsen over time.

Other Care Options: Rest, over-the-counter pain relievers, physical therapy, medications, injections, or surgery.

Your Rights and Responsibilities:

Your Right to Choose: You can stop or modify your care plan at any time. Just let us know what you're comfortable with.

Your Responsibility: Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.

Section 2: SoftWave (ESWT) Suitability Questions

Please answer the following to help us determine if SoftWave Tissue Regeneration is appropriate for you:

- Has the patient been injected with cortisone this month? ☐ Yes / ☐ No
- Has the patient been diagnosed with cancer/tumor within the last 12 months? ☐ Yes / ☐ No
- Has the patient been diagnosed with a skin infection in the last 12 months? ☐ Yes / ☐ No
- If patient is 12 or older: Is the patient pregnant or possibly pregnant? ☐ Yes / ☐ No
- Is the patient under 16 years of age? ☐ Yes / ☐ No

Our Commitment to You We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

Section 3: Decompression Suitability

Please circle any that apply to you:

☐ Pregnant ☐ Metal implants in spine ☐ Advanced Osteoporosis ☐ Hernia ☐ Blood Thinners ☐ Spinal Fusion
☐ Fractured or Broken Vertebra ☐ Failed Back Surgery ☐ Tumor ☐ Cardiac or Pulmonary Disease
☐ Abdominal Aortic Aneurysm
☐ Other (related to today's treatment): _____

Photos and Text Reminders: By signing this form, you also agree to the following (please cross out any that you want to opt out of):

- **Photos for Social Media:** I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time. ☐ Opt out of photos for social media
- **Text Appointment Reminders:** I agree to receive text reminders for my appointments to help me stay on track. ☐ Opt out of text appointment reminders

Your Consent: By signing below, I confirm that:

- I have read and understood this form, and my questions have been answered to my satisfaction.
- I understand the benefits, rare risks, and alternatives to chiropractic care.
- I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.
- I understand I can stop or change my care plan at any time.

Patient Name (Printed):	Patient Signature:	Date:
Parent/Guardian Name (if applicable):	Parent/Guardian Signature:	Date: