

GENERAL HEALTH HISTORY

Patient Name _____

Mark the conditions that apply to you.

Past Present

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Other _____

Past Present

- Vision Problems
- Sleeping Problems
- Chronic Colds/Sinus
- Scoliosis
- Temper Tantrums
- ADHD/Spectrum Disorder
- Seizures
- Delayed Developmental Milestones (trouble walking or crawling)

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

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

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

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

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

16. 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? _____

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Cell Phone _____ Marital Status: _____ Gender M F Significant Other's Name _____
 Have you been to a chiropractor before? No Yes When was your last Chiropractic Appointment? _____
 Your Employer _____ Type of Work _____
 E-Mail Address _____ Who Referred you to us? _____
 Emergency Contact _____ Ph # _____
 Name of Medical Doctor(s) _____

- 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.
- 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.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

Patient / Parent 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? _____
 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 Pain radiates to _____

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

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

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

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

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

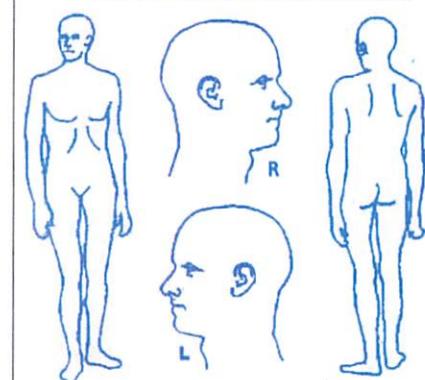
Are you pregnant?

Yes No

How far along? _____

Due Date: _____

Please mark all areas of concern.



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

- Most Auto related injuries are covered 100% in Ohio for patients not at fault. You can get the care you need and it normally costs nothing. Great for you!
- 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 for Care at 614 Chiropractic

Dear Patient (or Parent/Guardian of the Patient Named Below), We are committed to providing you with safe, effective, and natural chiropractic care to support your health and wellness. Please read this form carefully to understand what to expect from your care, its benefits, and any rare risks. If you have any questions, please ask us—we're here to help!

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. These adjustments aim to improve your body's alignment, movement, and overall function, helping you feel your best naturally.

What to Expect During Your Care:

- **Initial Evaluation:** We'll start with a thorough health history and physical exam, which may include checking your posture, movement, muscle strength, and other tests to understand your needs. In some cases, X-rays may be recommended to get a clearer picture of your health.
- **Personalized Care Plan:** Based on your evaluation, we'll create a tailored plan that may include adjustments, soft tissue therapies, exercises, nutritional advice, or home care recommendations. If needed, we may refer you to other healthcare professionals for additional support.

Benefits of Chiropractic Care: Chiropractic care helps many patients feel better and live healthier lives. Potential benefits include:

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

Every patient is unique, so results may vary. We'll work closely with you to support your health goals.

Understanding Rare Risks

Chiropractic care is very safe, but like any healthcare approach, there are rare risks. We take every precaution to ensure your safety, including a thorough evaluation to identify any concerns. Possible risks, though very uncommon, may include:

- Temporary soreness or discomfort after adjustments (similar to how you might feel after exercise).
- In very rare cases, minor muscle or ligament strain.
- Extremely rare risks, such as irritation to a disc or nerve, or, in exceptional cases involving neck adjustments, a very low risk of stroke (estimated at less than 1 in 1 million, much lower than risks from everyday activities like driving).

We use your health history, exam, and X-rays (if needed) to minimize these risks. Please share any health conditions or concerns with us, as this helps us tailor your care to keep you safe.

What Happens if You Choose Not to Pursue Chiropractic Care? If you decide not to proceed with chiropractic care, you may continue to experience discomfort, limited mobility, or other symptoms. Over time, untreated issues could worsen, potentially leading to longer recovery times or more complex treatments. We're here to discuss all your options to help you make the best choice for your health.

Other Care Options: Instead of or in addition to chiropractic care, you might consider:

- Rest or over-the-counter pain relievers.
- Physical therapy, medical care, or prescription medications.
- In some cases, advanced options like injections or surgery.

We'll help you understand these options and how they compare to chiropractic care.

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.

Photos and Text Reminders: By signing this form, you also agree to the following (please check the boxes to opt in or out):

- **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.
- **Text Appointment Reminders:** I agree to receive text reminders for my appointments to help me stay on track.

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.

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.
- I agree to the checked options above regarding photos and text reminders.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

Date: _____

