Patient Name: ____Preferred Name: ______________
Parent/Guardian: ___________________________ Parent/Guardian #2:____________________________
Address: __________________________________ City: _________________ State:______ Zip: _________
E-Mail: ____ Preferred Pronouns:_________
Home Ph: ________________________ Cell: __________________ Carrier (for texts):________________
Sex:______ Weight:___________ Height: ________ Birth Date: _____________________________

How Did You Hear About Us?: ☐Online ☐Drive-By ☐Referral: ________________ ☐Other: _____________

Purpose of Visit? ____
Other Doctors Seen for this Condition: Y N Doctors' Names/Prior Treatment: ____________________
Other Health Problems? ____
Check any of the following conditions your child has experienced during the past six months:

□Ear Infections	□Scoliosis	□Seizures	□Chronic Colds	□Headaches
□Asthma/Allergies	□Digestive Problems	□ADHD	□Recurring Fevers	□Growing/Back Pains
□Colic	□Bed Wetting	□Car Accident	□Temper Tantrums	□Other ____________

Family History: ____
Name of Pediatrician: ____
Date of Last Visit: ______/_____/_________ Reason: ____
Are you satisfied with the care your child received there? ☐ Yes ☐No
Number of Doses of Antibiotics Your Child has Taken:
During the Past Six Months ______ Total During Lifetime: ______
Other Prescription Medications Your Child has Taken: ____
During the Past Six Months ______ Total During Lifetime: _________ List: ____________________________
Vaccination History:____

PRENATAL HISTORY

Name of Obstetrician/Midwife: ____
Complications during Pregnancy? ☐ Yes ☐No List: ___________________________________
Ultrasounds during Pregnancy? ☐ Yes ☐No Number: ________
Medications during Pregnancy/Delivery: ☐ Yes ☐No List: ___________________________________
Cigarette / Alcohol Use During Pregnancy: ☐ Yes ☐No
Location of Birth (Circle one) Hospital Birthing Center Home Other _____________
Birth Intervention: (Circle All That Apply) Forceps Vacuum Extraction Epidural
Spontaneous Vaginal Birth: ☐ Yes ☐No Cesarean Surgery: ☐ Yes ☐No (Emergency or Scheduled?)
Complications During Delivery? ____
Genetic Disorders or Disabilities? ____
Birth Weight: _______ Birth Length: _______ APGAR Scores: _______, ________

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FEEDING HISTORY

Breast Fed ☐ Yes ☐No How Long: ________________________

Formula Fed ☐ Yes ☐No How Long: ________________________ Type: ___________________________

Introduced to solids at: ________ Months Cow's Milk at: ________ Months

Food / Juice allergies or intolerances: ☐ Yes ☐No 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 _______ Cross Crawl _____ Respond to Visual Stimuli

_______ Stand Alone ______ Hold Head Up _______ Walk Alone _______ Sit up

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? ☐No ☐Yes

Has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ☐ Yes ☐No List: _____________________________________

Has your child ever been involved in a car accident? ☐ Yes ☐No List: _________________________________

Has your child ever been seen on an emergency basis? ☐ Yes ☐No List: ______________________________

Other traumas NOT described above? ☐ Yes ☐No List: ____

Prior Surgery: ☐ Yes ☐No List:____

CHILDHOOD DISEASES

Chicken Pox ☐ Yes ☐No Age ____

Rubella ☐ Yes ☐No Age ____

Rubeola ☐ Yes ☐No Age ____

Mumps ☐ Yes ☐No Age ____

Pertussis ☐ Yes ☐No Age ____

Other ☐ Yes ☐No Age ____

List: _____________________________

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed _____________________________________ Print Name____________________________________

Date______________________________ Relationship to Patient:________________________________

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TERMS OF ACCEPTANCE

If a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us 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 forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of verve 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 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 advise, 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.

CONSENT TO CARE

I do hereby authorize the doctors of Ferguson Family Chiropractic to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and shall be personally liable for any and all of the unpaid balance to the doctor.

I, ______________________________ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: ________________________________ Date: _______________

Signature of parent or guardian if minor

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HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information.

The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Ferguson Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following.

SPECIFIC AUTHORIZATIONS

- I give permission to FFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If FFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to FC to use my name on a welcome board, referral board and birthday board.
- I give permission to FFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on the their website or in ads in print media.
- I give FFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at FFC plus 7 years or until revoked by me.

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RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action to reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information:

Your name, Social Security number & date of birth;
A clear statement of you intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. (Minimum necessary standards apply)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: ___________________________ DOB: _______________________________
My Name (please print): ____
My Signature: ____
Today's date: _______________________________

Name of personal representative (if someone is designated to act on your behalf)
Name (please print): ____
Signature of Personal Representative: ____
Description of Representative's Authority to Act on Patients Behalf: __________________________

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