

Practice Member
(newborn-12 years)

Last Name _____ First Name _____
Address _____ City _____ State _____ Zip _____
DOB _____ Age _____ SS# _____
Home Phone _____ Cell Phone _____
Mother _____ Father _____
Email (Parent's) _____ May we send you office newsletters? Yes No
Who may we thank for your referral to our office? _____
Has your child ever received chiropractic care? Yes No
If so, when was their last visit? _____

List all drugs your child is taking (including prescription and non-prescription drugs, such as asthma medication, Tylenol, cold tablets, and allergy medicine)

Medication _____	Purpose _____
Medication _____	Purpose _____
Medication _____	Purpose _____
Medication _____	Purpose _____

Does your child take any Vitamins or Herbs? Yes No Prescribed by: _____
Does your child drink filtered/bottled water? Yes No

Children (only newborns - 6 years old)

Birth:

Forceps used Vacuum Extraction Cesarean Section (planned: YES NO)

Were there complications during delivery? No Yes, _____

Were you given an epidural? Yes No

Birth Weight _____ Birth Length _____

Breast fed: No Yes, how long? _____

Formula fed: No Yes, how long? _____

Introduced to Solids at: ____ Months Cow's milk at: ____ Months

Food / Juice Allergies or Intolerances _____

When was your child's most recent fall? _____ What happened? _____

Which high impact, or contact type sports, is your child involved (such as Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____

Has your child ever been involved in a car accident? No Yes, (dates / any treatment)

Has your child ever been seen on an emergency basis? No

Yes (please list all) _____

Which of the below conditions has your child experienced? Mark all those that your child is currently experiencing with a star.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bowel Control Loss | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> V.D. |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Dystrophy | |

Which of the above conditions do you expect to be helped with chiropractic care?

Has your child been vaccinated? No Yes, which ones? _____

When was the last vaccination? _____ Which vaccination was it? _____

Childhood Diseases:

- | | | | |
|--------------------------------------|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Rubeola | <input type="checkbox"/> Other _____ | | |

I understand that I may be contacted by phone.

Consent for treatment for minor:

I hereby authorize Dr. Ray Wisniewski and whomever he may designate as assistants to administer examination and chiropractic care as deemed necessary to:

Name of child

Signature of parent or guardian

Date

REVIEW OF SYSTEMS

PATIENT NAME _____

DATE _____

Please mark all that apply to your health condition:

General

- Fever
- Unexplained Weight Loss
- Fatigue
- Lightheaded
- Fainting
- Memory Loss
- Loss of Balance
- Loss of Sleep
- Headaches
- Jaw Pain
- Skin Lesions
- Other _____

Eyes

- Blurred Vision
- Double Vision
- Cloudy Vision
- Flashes of Light
- Sensitivity to Light
- Other _____

Ears

- Hearing Loss
- Ringing in Ears
- Other _____

Nose

- Loss of Smell
- Runny Nose
- Other _____

Throat

- Sore Throat
- Other _____

Mouth

- Dry Mouth
- Ulcers
- Cold Sores
- Other _____

Cardiovascular

- Cold Hands
- Cold Feet
- Chest Pains
- Blue Lips
- Blue Nails
- Irregular Heartbeat
- Other _____

Respiratory

- Chest Congestion
- Shortness of Breath
- Difficulty Breathing
- Other _____

Gastrointestinal

- Abdominal Pain
- Nervous Stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Heartburn
- Indigestion
- Loss of Appetite
- Other _____

Genitourinary

- PMS
- Irregular Periods
- Impotence
- Painful Urination
- Inability to Urinate
- Other _____

Musculoskeletal

Aches or Pains in the:

- Neck
- Upper Back
- Lower Back
- Arms
- Legs
- Hands
- Feet
- Other _____

Psychological

- Nervousness
- Irritability
- Depression
- Tension
- Other _____

Other

NAME _____

DATE _____

HISTORY OF PRESENT ILLNESS

Complaint #1 _____

When did it start? _____

What were you doing when it started? _____

What makes it better? _____

What makes it worse? _____

Is it mild, moderate or severe? _____

Complaint #2 _____

When did it start? _____

What were you doing when it started? _____

What makes it better? _____

What makes it worse? _____

Is it mild, moderate, or severe? _____

Complaint #3 _____

When did it start? _____

What were you doing when it started? _____

What makes it better? _____

What makes it worse? _____

Is it mild, moderate, or severe? _____

Complaint #4 _____

When did it start? _____

What were you doing when it started? _____

What makes it better? _____

What makes it worse? _____

Is it mild, moderate, or severe? _____

EXAM

Patient Name _____ Date _____

1) Has anyone recommended/prescribed medication or surgery for this condition? Yes No

2) Are you currently taking ANY medications? Yes No
Please List ALL Medications:

3) What have you done for your condition yourself and did it help?

4) Have you ever had surgery or been hospitalized?
Yes No (What was the surgeries & when)

5) Have you ever had any previous auto or work related accidents? Yes No (Date / Describe)

6) List all doctors/hospitals or testing facilities that you've sought care at for this condition:

	<u>Name</u>	<u>Address & Phone #</u>
a)	_____	_____
b)	_____	_____
c)	_____	_____

7) Patient MUST Sign A Records Release Form!

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose Your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We utilize sign in sheets, which may be seen, by other patients and call patients by name. If this is unacceptable please inform the office personnel, and other arrangements for you will be made.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for your health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

For more information or to file a complaint:

The US. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue,
S.W. Washington, D.C. 20201
Toll Free: 1-877-696-6775

I (print) _____ have received a copy of this office's Notice of Privacy Practices.

(signature) _____ (date) _____

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 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 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.

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 another health care provider.

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 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.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

(Signature of patient)

(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-rays can be hazardous to an unborn child. Date of last menstrual period _____.

Signature

Date