Time_____ **RM**____

_____ **T 1 2 3**

Name_____Date of Birth_____/_____/_____Age_____ Male / Female

Address_____City_____State_____Zip_____

Parent/Guardian Name(s)_____Relationship(s)_____

Phone Number_____Siblings_____

Child's Social Security #_____Weight_ _____Height_ _____

Who may we thank for referring you?_____ Office Only _____

LIST YOUR HEALTH CONCERNS BELOW:

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

Chiropractor?_____Medical Doctor?_____Other_____

Who and When?_____

Result of Care_____

PLEASE MARK "**P**" FOR IN THE **PAST** OR MARK "**C**" FOR **CURRENTLY** HAVE:

___HEADACHE/MIGRAINE	___HEARING LOSS	___LOSS OF ENERGY	___LOSS OF BALANCE
___EAR INFECTIONS	___SLEEP PROBLEMS	___POOR POSTURE	___BACK/NECK PAIN
___SCOLIOSIS	___EATING PROBLEMS	___TIGHT/SORE MUSCLES	___BLADDER PROBLEMS
___ADD/ADHD	___GASTRIC REFLUX	___ANXIETY	___DIGESTIVE PROBLEMS
___BED WETTING	___ANXIETY	___FREQUENT COLDS	___HEART PROBLEMS
___DEVELOPMENTAL DELAY	___DEPRESSION	___DIABETES	___KIDNEY PROBLEMS
___GROWING PAINS	___NERVOUSNESS	___LEG/ARM/JOINT PAIN	___THYROID PROBLEMS
___SCOLIOSIS	___CONSTIPATION	___JAW PAIN	___SPORTS INJURY
___SEIZURES	___DIARRHEA	___ULCERS	ANY KNOWN DIAGNOSES__
___SINUS ISSUES	___NAUSEA	___RINGING IN THE EARS	_____
___ASTHMA	___ALLERGIES	___DOUBLE/BLURRY VISION	_____
___DIFFICULTY BREATHING	___SKIN PROBLEMS	___DIZZINESS	_____

Pregnancy Information

Briefly describe your pregnancy_____

Any pregnancy complications?_____

Any drugs/medication during pregnancy?_____

Other information_____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section

None

Induced Labor? YES / NO

If yes, please explain_____

Medications received during delivery_____

Other information_____

_____

Post Partum Information

Birth Weight_____Birth Length_____APGAR SCORE_____

Breast Fed? YES / NO How long?_____ Formula Fed? YES / NO How Long?_____

Age Introduced to Solid Foods_____

Food Allergies or Intolerances_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____Total lifetime _____

Current prescription medication/dosage?_____

Over the counter medication (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years_

_____

Has your child ever been knocked unconscious? YES / NO Fractured A Bone? YES / NO

If yes to either, please describe_____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If there is more than one condition, please answer each question for each individual complaint and indicate the score of each complaint.

EX: No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Headache *Hip Pain*

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain? (How bad is your pain throughout most of a day?)

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst?_____%

Activities Of Life

Please identify how your child's ability to carry out activities that are routinely part of life are affected by current condition

ACTIVITIES:	EFFECT:			
Holding Head Up	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Tummy Time	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Nursing	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Sitting Up	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Crawling	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Standing Alone	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Walking Alone	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Difficult/Painful	☐ Limited/Very Painful	☐ Unable to Perform

LIST RESTRICTED ACTIVITY LEVEL	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Written Consent For A Child

CHILD'S NAME_____

I AUTHORIZE DR. SAM SAWYER AND ANY PARADIGM CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY PARADIGM CHIROPRACTIC.

_____ _____ _____/_____/_____
Guardian Name Guardian Signature Date

_____
Relationship to Minor / Child

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____/_____/_____
Signature Date

X-Ray Authorization

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.
PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF PARADIGM CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____/_____/_____ _____
Signature Date Age

Medical Information Release Form

Name_____Date of Birth_____/_____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.
This information may be released to:

[ ] Spouse_____
[ ] Children_____
[ ] Other_____
[ ] My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

_____ _____/_____/_____
Signature Date

Authorization For Use Or Disclosure Of Photographic And/Or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Paradigm Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images and/or testimonial will be used for: *In-office material*, *Merchandise*, *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy can be provided:
☐ *"Yes, I would like a copy of this form."*
(team member initials)

Name_____

Date_____

Signature_____

If Personal Representative

Name_____

Date_____

Signature_____

Relationship to Patient_____

If Patient is a Minor

Parent Legal Guardian_____

Date_____

Signature_____

_____ _____/_____/_____

Paradigm Chiropractic Team Member Date