

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.)

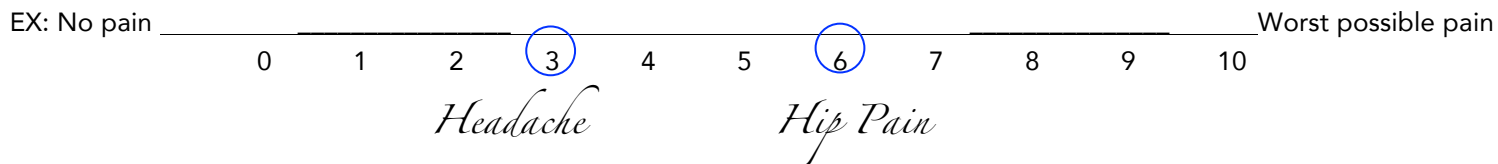
List all surgical operations & years_

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

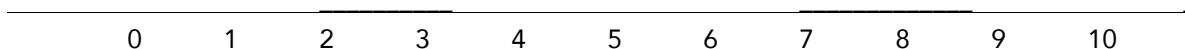
If yes to either, please
describe_____

Quadruple Visual Analogue Scale

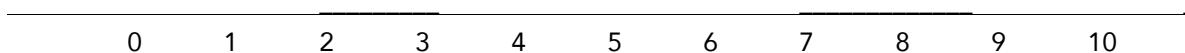
Please circle the number that best describes the question asked. If there is more than one condition, please answer each question for each individual complaint and indicate the score of each complaint.



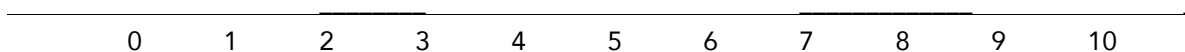
1. How would you rate your pain RIGHT NOW?



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

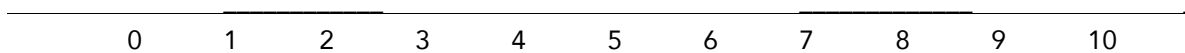


3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



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?)



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	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Tummy Time	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Nursing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Crawling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Standing Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Walking Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> 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