Moore Chiropractic Office Date: _____

CHILD'S PERSONAL DATA

Name _____ Age _____ Date of Birth _____ Gender: ❑M ❑F
Home Address _____ City _____ State _____ Zip _____
Names and Ages of Siblings_____

Parent A

Name _____
Home phone (_____) _____
Cell phone (_____) _____
Employer _____
E-mail _____

Parent B

Name _____
Home phone (_____) _____
Cell phone (_____) _____
Employer _____
E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Moore Chiropractic Office can address for you? _____

_____

_____

Are these concerns affecting your child's quality of life? (Please circle all that apply)

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

Other:_____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received Chiropractic care? Yes___ No___ Name of D.C._____
Reason_____How long ? _____ Date of last visit:_____
Why was care stopped?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑Medical Physician ❑Naturopath ❑Acupuncturist ❑Homeopath

❑Massage Therapist ❑Psychotherapist ❑Energy Healer ❑Other_____

Reason:_____

_____ __

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.
Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below helps the chiropractor see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating **Vertebral Subluxations**.

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? List:_____
❑ Take any drugs/medications? List: _____
❑ Smoke or consume alcohol? List: _____

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was the child in a breech position (butt down) or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check where the baby was born and if any of the following were administered during labor and birth.

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean
❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck

Please check all that apply to the baby's status immediately after birth: APGAR Score _____

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone _____
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.

If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT	_____	❑ MMR	_____	
❑ Polio	_____	❑ Chicken Pox	_____	❑ Other _____
❑ Hepatitis	_____	❑ Flu	_____	

Please describe any and all reactions to vaccine(s) _____

Please check all that apply and give any necessary details:

❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

EMOTIONAL STRESS:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Symptomatic relief of a problem
❑ Correction of the cause of a problem as well as relief.
❒ Prevention of future problems
❒ Healthier spine and nerve system
❒ Optimal health on all levels
❒ Other_____

IMPORTANT INFORMATION: It is NOT true that "no shots—means no school". Vaccines are dangerous and always depress the childs' immune system. (There is ample scientific literature on this matter.) The Commonwealth of Massachussetts provides for a legal waiver of these "routine" vaccinations. We have them on file and will assist you in keeping your child free from these dangerous and sometimes fatal vaccines. Regarding vaccine "injuries": "When it happens to your child, the risk is 100%."

❑ **I want to know more about this.**

Consent Form

1. I have been informed that a copy of Moore Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office Yes____ No____
2. I understand that most care is given in an open setting. Private rooms are available upon request
3. I consent to receive communication from WFC via email, postal mail, text and telephone messaging in connection with my care. Yes___ No___
   If I should withdraw my consent, I will notify the office in writing.
4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Yes___ No___

Our Unique Approach to Finances at Moore Chiropractic

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. For that reason, we utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary at affordable fees. Our plans also allow **unlimited visits for a fixed fee**, similar to a health club. This gives our practice members the unique opportunity to maximize their results and regain and sustain their health and function without worrying about finances. These plans will be discussed with you on your second visit once we have determined your goals and the amount and type of care you need.

Insurance

Insurance coverage varies greatly. We cannot predict whether your policy will reimburse you for any of the services we provide in our office. It is your responsibility to contact your insurance company to determine the amount and extent of coverage. If you determine that your insurance will reimburse you for chiropractic care in our office, we will provide you **with itemized monthly statements** for **you** to submit.

If you have had an **Auto Accident, a Worker's Compensation Injury or a Personal Injury**:
Have you been treated for injuries? Yes___ No___ If yes, where? _____
What services were provided? _____

Name: (Printed) _____Date: _____
Signature:_____

Signature of Parent (for minor):_____
Child's Name: (Printed) _____
Parent or Legal Guardian's Name: (Printed)_____
Date:_____

Welcome and thank you for choosing Moore Chiropractic Office!