Child: Danville Chiropractic: 1995 East Main Street, Danville, IN 46122 Phone: 317-745-5100

Name: _____ Date of Birth: _____/_____/_____

Preferred to be Called: _____Social Security #_____-_____-_____

Address: _____City:_____ State:_____ Zip:_____

Parent #1 Name: _____ Cell/Alt Phone# (_____)_____

Parent #2 Name: _____ Cell/Alt Phone# (_____)_____

Parents Email address: _____

Who may we thank for referring you in? _____

How did you hear about us? ☐ Referral ☐ Mail ☐ Facebook ☐ Google ☐ Location ☐ Insurance ☐ Walk-in ☐Other_____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other _____

Primary Insured Name: _____ Date of Birth: _____/_____/_____

Primary ID/Member Number:_____ Group #:_____

Name of Secondary Insurance Company (if any):_____

Relationship to Secondary insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐Other _____

Secondary Insured Name: _____ Date of Birth: _____/_____/_____

Secondary ID/Member Number: _____ Group #:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Peak Health Chiropractic PC dba Danville Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. **In consideration of the services to be provided to the customer/patient, I/we hereby guarantee payment in full of the customer's account in accordance with the financial arrangements made at the time of service/purchase or, if no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due to the account, plus any applicable court costs. You expressly consent and agree to Peak Health Chiropractic PC, dba Danville Chiropractic and their affiliates, agents and service providers may use written, electronic and verbal means to contact you. This consent includes but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails, and/or automatic telephone dialing systems. You agree that Peak Health Chiropractic PC dba Danville Chiropractic and their affiliates, agents and service providers may use any email address or telephone number you provide, now and in the future, including a number for cellular phone or other wireless device, regardless of whether you incur charges as a result.**

PLEASE NOTE: **P**ayment is due in full at the time of service. **We DO accept insurance assignment, but NOT until we are able to contract your insurance carrier directly to verify benefits which is not a guarantee of payment.** The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you want to receive your medical records, please inform our office.

By Signing you are authorizing Danville Chiropractic to perform a complete examination, provide chiropractic care, and other therapeutic treatments to your minor. This authorization is also intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the above minor. (if applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other legal authorization is not required. If my authorization to so select and authorization this care should be revoked or modified in any way, I will immediately notify the office.

Guardian's Signature: _____ Date: _____/_____/_____

Relationship to Minor: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Name: _____ Date of Birth: _____/_____/_____

BIRTH INFORMATION (PLEASE ANSWER FOR AGES 5 AND UNDER)

Type of Birth:(Check all that apply) ☐ Vaginal ☐ Forceps ☐ Breech ☐ Cesarean ☐ Water ☐ Home ☐ Other_____

☐ Adoption at age_____ ☐ Birthing Center_____ ☐ Hospital_____

Birth Weight: _____Birth Length _____ Apgar Score: _____

At Birth Jaundice (yellow) ☐ Yes ☐ No _____ Epidural ☐ Yes ☐ No

Please list **ANY** problems during Pregnancy and/or labor: _____

_____

_____

Congenital Anomalles/Defects: _____

Infant Feeding (check all that apply) ☐ Breast ☐ Bottle ☐ Formula ☐ Other_____

# of Hours child sleeps daily: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Explain: _____

Siblings: _____, List Names and Ages : _____

MEDICAL HISTORY:

Pediatrician and/or Family Medical Doctor: _____ Telephone #_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Date of Last Visit with Doctor: _____/_____/_____ Reason for Visit :_____

Immunization History: _____

_____

Has your Child ever been treated on an emergency basis ☐ No ☐ Yes Please Describe _____

_____

Developmental History- at what age did the child

Respond to sound:_____ Crawl:_____

Follow and Object with their eyes:_____ Hold up Head:_____

Stand:_____ Sit Alone:_____

Walk Alone:_____

FAMILY HISTORY:

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **G Grandparent**):

Mental Illness	☐ M	☐ F	☐ B	☐ S	☐ G	Cancer	☐ M	☐ F	☐ B	☐ S	☐ G
Diabetes	☐ M	☐ F	☐ B	☐ S	☐ G	Asthma	☐ M	☐ F	☐ B	☐ S	☐ G
Arthritis	☐ M	☐ F	☐ B	☐ S	☐ G	Headaches	☐ M	☐ F	☐ B	☐ S	☐ G
Back Problems	☐ M	☐ F	☐ B	☐ S	☐ G	Disc Problems	☐ M	☐ F	☐ B	☐ S	☐ G
Joint Problems	☐ M	☐ F	☐ B	☐ S	☐ G	Neck Problems	☐ M	☐ F	☐ B	☐ S	☐ G

Mental Illness	☐ M	☐ F	☐ B	☐ S	☐ G						
Scoliosis	☐ M	☐ F	☐ B	☐ S	☐ G						
Bad Posture	☐ M	☐ F	☐ B	☐ S	☐ G						
Multiple Sclerosis	☐ M	☐ F	☐ B	☐ S	☐ G						
Other:_____											

Name: _____ Date of Birth: _____/_____/_____

HEALTH INFORMATION

1. Reason for Visit today? _____
2. Condition Started on? _____
3. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? ☐Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how? _____
4. How frequent is the condition? ☐ Constant ☐ Frequent ☐ Occasionally ☐ Intermittent ☐ Night Only

   How long does it last? ☐ All Day ☐ Few Hours (range):_____ ☐ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?

   ☐ Yes ☐ No If yes, describe: _____

   Are there other unrelated health problems? ☐Yes ☐ No. If yes, describe _____

   _____
6. Other Healthcare Professionals seen for this condition? _____
7. Is there anything you can do to relieve the problem? ☐ Yes ☐ No. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
8. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

   ☐ Other_____
9. List any **major accidents or surgeries** you have had other than those that might be mentioned above

   _____
10. Previous Chiropractic Experience ☐ Yes ☐ No Who?_____
12. Other Medical Professionals Seen for Condition_____
13. Has the Child Ever suffered from any of the following (please check all that apply)

☐ Diabetes	☐ Bed Wetting	☐ Convulsions	☐ Neck Problems	☐ Asthma
☐ Fainting	☐ Tuberculosis	☐ Backaches	☐ Heart Trouble	☐ Dizziness
☐ Stomach Aches	☐ Allergies	☐ Orthopedic Problems	☐ Walking Problems	☐ Rheumatic Fever
☐ Hypertension	☐ Sugar Concentration	☐ Leg Problems	☐ Broken Bones	☐ Sleeping Problems
☐ Digestive Disorders	☐ Diarrhea	☐ Constipation	☐ Paralysis	☐ Joint Problems
☐ Arm Problems	☐ Hyperactivity	☐ Chronic Earaches	☐ Colds/Flus	☐ Arthritis
☐ Neuritis	☐ Anemia	☐ Poor Appetite	☐ Behavior Problems	☐ Muscle Jerking
☐ Rupture/Hernias	☐ "Growing Pains"	☐ Any Other Problems_____		

14. Notes: _____

_____

_____

_____

_____

_____