Today's Date: ______/______/______

Name: ____ Birth Date: ____/____/____ Age: ____ Male/Female

Weight: ___________________ Height: _______________________

Guardian(s) Name: ____ Relationship: ____________________________________

Address: ____ City: ____________________ State: ______ Zip: ____________

Phone: Home ( )_____________________ Work ( )______________________ Cell ( )______________________

Email Address: ____

Have you seen a chiropractor before? Yes No If yes, when?: ____

Whom may we thank for referring you to our office?: ____

YOUR HEALTH HISTORY

Please ✔ check all symptoms you have ever had, even if they do not seem related to your current problems

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Numb/Tingling Arms/Hands (L/R)
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Colic	___ Numb/Tingling Legs/Feet (L/R)
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Torticollis	___ Allergies
___ Neck Pain	___ Dizziness	___ Asthma	___ Autism	___ Behavioral Issues
___ Shoulder Pain (L/R)	___ Loss of Energy	___ Difficulty Breathing	___ Sensory Issues	___ Mood Swings
___ Elbow/Wrist Pain	___ Sleep Problems	___ Nausea	___ Seizures	___ Excessive Tantrums
___ Upper Back Pain	___ Double/Blurry Vision	___ Ulcers	___ Epilepsy/Convulsions	___ Reflux
___ Mid Back Pain	___ Anxiety	___ Stomach Issues	___ Tremors	___ Heart Problems
___ Lower Back Pain	___ Nervousness	___ Digestive Issues	___ Disc problems	___ Cancer
___ Hip/Leg Pain (L/R)	___ Depression	___ Diarrhea	___ Scoliosis	___ Spinal Bone Fracture
___ Sciatic Pain (L/R)	___ Loss of Balance	___ Constipation	___ Poor Posture	___ Spinal Surgery
___ Knee (L/R)	___ ADD/ADHD	___ Bed Wetting	___ Skin Problems	___ Diabetes (Type 1 or 2)
___ Foot (L/R)	___ Arthritis/Joint Pain	___ Bladder Problems	___ Other: ______________________________	

Main Complaint: ____

List any medications presently taking: ____

Have you been in a car accident recently? Yes No If so, when?: ____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: ____ Date: ____________________________

Guardian Signature: ____ Date: ____________________________
(if 18 years or younger)

Pregnancy Information:

How was your pregnancy? ____

Any Pregnancy Complications? ____

Did you take any medication during your pregnancy? ____

Other Information: ____

Delivery Information:

Location of Birth: (circle one) Hospital Birth Center Home

Birth Intervention: (circle one) Induction Forceps vacuum Extraction caesarean section

____

Induced? Yes / No Explain: ____

Medications during delivery? ____

Other Information: ____

Post Birth Information:

Birth Weight: ____________________________ Birth Length: _____________________

Breast Fed: Yes / No How long? ____________________ Formula Fed: Yes / No How Long? _______________________________

Introduced Solid Foods at _____________ months

Food Allergies or intolerances: ____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months __________ Lifetime ________________

Over the counter drugs (Tylenol, Cough Syrup, Laxatives, etc.) ____

____

List all Surgical operations / hospitalizations / slips/falls and year of occurrence: ____

____

Has your child ever been knocked unconscious? ☐ Yes ☐ No Fractured a bone? ☐ Yes ☐ No

If yes to either of the above, please describe: ____

____

Does your child have difficulty turning their head? ☐ Yes ☐ No If yes, which way? _______________________________________

Does your child arch their neck/back or have involuntary movements or restriction with movements? ___________________________

____

Activities of Life

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their life or milestones they are struggling to meet.

List Restricted Activity	Current Activity Level	Usual Activity Level
Example: Crawling all around	Not crawling hardly at all	They used to be able to crawl no problem

Outcome Assessment Tool

Please **circle** the number that best describes the question asked for the **MAIN COMPLAINT.**

EXAMPLE:

No pain ____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain **RIGHT NOW**?

No pain ____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical **AVERAGE** pain?

No pain ____Worst Possible Pain
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?)

No pain ____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain ____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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 (HIPPA). 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: ________________________

Guardian Signature: ____ Date: ________________________

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 ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone.

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

Signature: ____ Date: ________________________

Guardian Signature: ____ Date: ________________________

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Joey Kelbel, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: ____

Signature: ____ Date: ________________________________

Guardian Signature: ____ Date: _________________________________

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below

Written Consent For A Child

Name of practice member who is a minor/child: ____

I authorize Dr. Joey Kelbel and any and all Discover Life 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 Discover Life Chiropractic.

Guardian Signature: ____ Date: ___________________________

Relationship to Minor/Child: ____

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. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Discover Life Chiropractic does 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.

Print Full Legal Name: ____ Date of Birth: _________________

Signature: ____ Date: __________________________________

Guardian Signature: ____ Date: _________________________________