Application For Care

Under 18 years old

Tell Us About You

Name _____ Date of Visit _____

Date of Birth _____ Age _____ Gender _____

Address _____

City _____ State _____ Zip _____

Best Phone Number to Reach You _____ SS# (if applicable) _____

School Grade _____ Number of Siblings _____ Ages _____

Health Information

Please list any past major illnesses, injuries, and surgeries: _____

_____

_____

Please answer the following regarding your child's birth: _____

Delivered in: *hospital* *home* *birthing center* *other* _____

Instruments used: *none* *forceps* *vacuum* *other* _____

Complexity of birth: *easy* *moderate* *difficult*

Complications: _____

_____

What brings you to The Adjustatorium today? _____

_____

What are your expectations and goals for chiropractic care? _____

_____

Is your child currently seeking the services of another healthcare provider? *Yes / No* Reason: _____

_____

Has your child ever seen a chiropractor before? *Yes / No* If yes, what was his/her experience? _____

_____

How many hours does your child sleep on an average night? _____

How would you describe the quality of your child's sleep? _____

Is your child currently taking any prescription, over the counter, or recreational drugs? *Yes / No* If yes, please list:

_____

_____

How many cups of caffeinated coffee, tea, or soda does your child drink on an average day? _____

How much water does your child drink on an average day? _____

Does your child exercise regularly? *Yes / No* If yes, please explain: _____

_____

Application For Care

under 18 years old (continued)

Health Information

Please describe your child's diet: _____

_____

Is your child on a special diet? Yes / No If yes, please describe: _____

_____

Please list your child's hobbies _____

_____

Is there anything else about your child and his/her body that you think we should know? _____

_____

_____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

Rules For Care

I am the legal parent/guardian of _____ .
I grant permission for this child to receive chiropractic care from Dr. Ryan K. Marchman.

This care will include a relevant spinal examination and specific chiropractic adjustments when necessary. Chiropractic care plays a key role a wellness lifestyle and with the use of hands, adjustments are delivered to the spine, freeing up subluxation or interference to the messages traveling in the nerve system. I understand that vertebral subluxation is the condition of blocked or abnormal flow of innate wisdom through the nerve system. I further understand that the sole purpose for chiropractic care at The Adjustatorium is to release vertebral subluxations and allow the body to work at its full potential. I understand that my child's body is self-healing and will function at a higher level when this interference is removed.

The Adjustatorium is a family practice and we want everyone in this family to feel at home here. To maintain this environment, we ask that there be no roughhousing, that toys are picked up and put away before leaving, and that each person shows respect for all others present. We understand that there are people who may be bothered or injured by this type of activity.

Parent/Guardian Signature _____ Date _____

DISCLOSURE *and* CONSENT *for* CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE CLIENT: You have a right as a client to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I certify that I'm the client or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine administer care as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I understand that I have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: the right to review the notice prior to consent, the right to request restrictions as to how my health information may be used or disclosed to carry out care, payment or health care operations.

As a Client of The Adjustatorium I understand that an open adjusting room is utilized, and with the nature of open adjusting rooms I acknowledge and accept that my personal information may be heard by another person in the office. If confidentiality is required, I agree to schedule a private appointment with The Adjustatorium staff to discuss my information.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name: _____

Signature of Client/or Representative: _____ Date Signed: _____

Member of Doctor's Staff: _____ Date Signed: _____