LANDMARK
CHIROPRACTIC

Child's Name: _____ Date: _____
Parent's/Guardians' Name: _____
Address: _____ City, State, Zip_____
Home Phone: _____ Parent's Cell Phone: _____
Parent's Email: _____
How did you hear about us? _____
Height (of child): _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____
Siblings and ages: _____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He/She is continuing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

Have you ever seen other Doctors for these conditions? YES / NO
CHIROPRACTOR?_____MEDICAL DOCTOR_____OTHER_____
WHO AND WHEN?_____

Does your child appear to be in pain or discomfort? _____ For how long? _____
Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____
What treatment did they use?
Has your child taken any medication for this complaint? ☐ No ☐ Yes:
Has your child ever experienced this complaint before? ☐ No ☐ Yes:
Has your child received any treatment at this time? ☐ No ☐ Yes:
Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes:
Has your child had any blood work done for the current complaint? ☐ No ☐ Yes:

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____
Medications during labor/delivery including IV antibiotics): ☐ No ☐ Yes: _____
Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes
Was your child at any time during pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure
If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation
Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____
If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech
Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other
Were there any complications during delivery? ☐ No ☐ Yes
If yes, please specify: _____
Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes
Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____
Was the baby ever admitted to the NICU? ☐ No ☐ Yes
If yes, for how long and why? _____
Was your child breastfed, formula fed, or both? _____
Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes _____
Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes _____
Has your child broken any bones? ☐ No ☐ Yes _____
Has your child had any previous hospitalizations? ☐ No ☐ Yes _____
Has your child had any previous surgeries? ☐ No ☐ Yes _____
Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day
Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally
Does your child sleep on their... ☐ Back ☐ Belly ☐ Sides (both, right, left)
Does your child carry a back pack? ☐ No ☐ Yes
Do your child's shoes show excessive or uneven wearing out? ☐ No ☐ Yes
Does your child wear custom orthotics?
☐ No ☐ Yes, For what purpose? _____

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 IS $60.00. 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 LANDMARK 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.

_____ _____
PRINT YOUR NAME HERE **DATE**

_____ _____
SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT LANDMARK CHIROPRACTIC.

_____ _____
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

CA Initials:
_____

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY NUMBER: _____ MARITIAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $40 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Andrew Oestreich DC. 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 patient. 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

Signed_____ **Date**_____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

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 PRATICES 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 disclosed 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)**

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 THIS 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.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					