Results Chiropractic, Inc.
Pediatric Chiropractic Re-Exam Intake Form

Patient (Child) Information:

Name:_____Nick Name:_____
Address:_____
Sex: Male Female Date of Birth:_____ Patient SSN:_____
Name of Parents/Guardians:_____
Home Phone:_____Cell Phone:_____Phone Carrier:_____
Would you like to receive appointment reminder via text Message: Yes No
Email:_____
Authorized Representative/Parent/Guardian:_____
Phone:_____

Present Complaint:_____
When did this begin?_____
Was there an accident or injury involved? Y or N If so, what was the accident or injury?
_____
Has your child had any past treatment for this complaint? Y N
Describe:_____
Current Medications:_____
Current Vitamin:_____

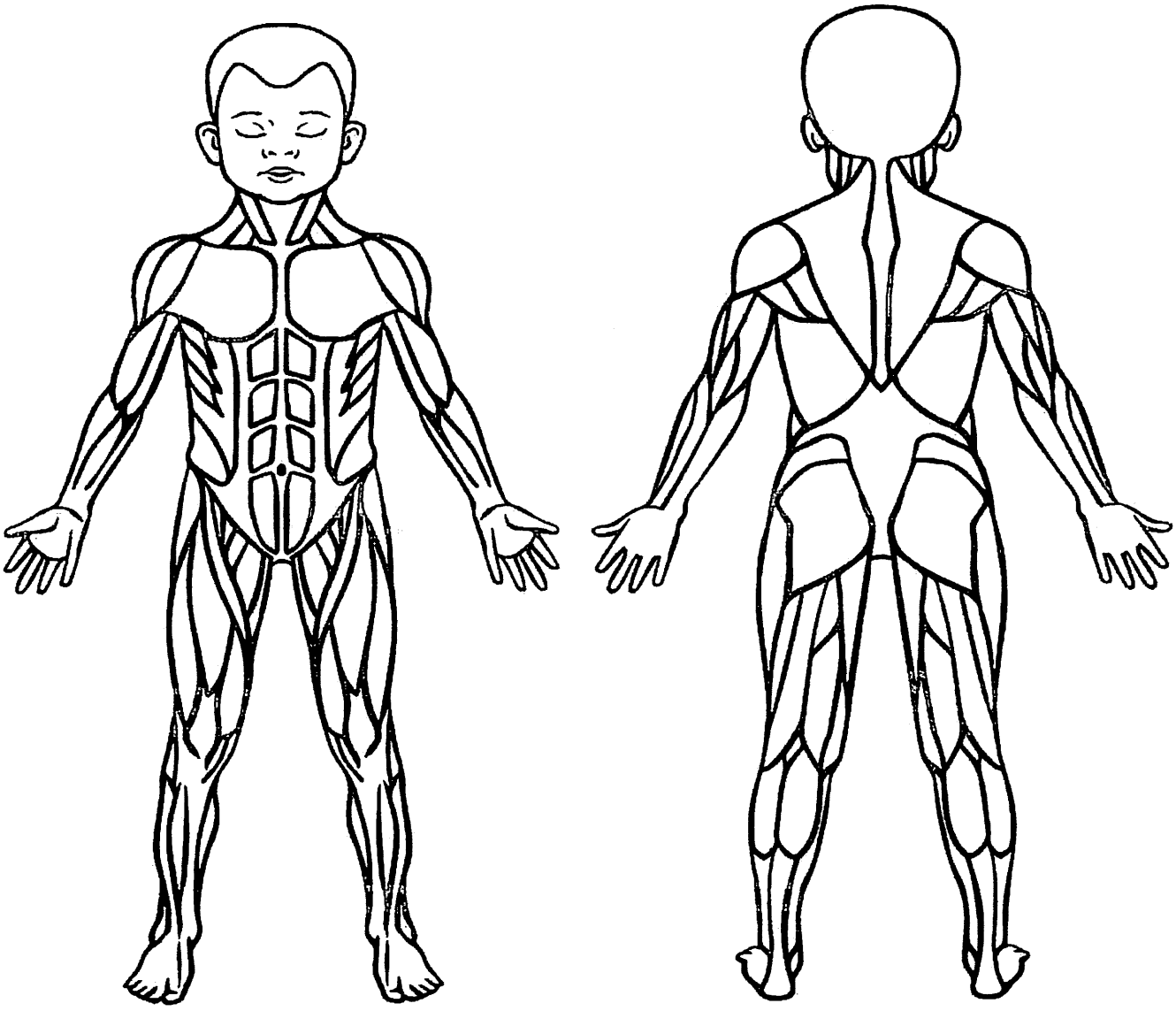
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheer leading, martial arts, wrestling, etc)? Yes No
If yes, please list along with any trauma or concussion associated with sport listed:_____
Has your child ever been involved in a car accident? Y N
Explain:_____
Other traumas not described above? Y N Explain:_____
Prior surgeries? Y N
List with dates of surgeries:_____

Review of Systems

Please check if your child has had any of the following:

_____Headaches	_____Postural Imbalance	_____Growing Pains	_____Scoliosis
_____Tonsillitis	_____Asthma	_____Torticollis	_____Ear Infections
_____Seizures	_____Sleep Problems	_____Digestive Problems	_____Bed wetting
_____PDD/Autism	_____ADD/ADHD	_____Frequent Fever	_____Allergies
_____Colic	_____Learning Difficulties	_____Acid Re flux	_____Hip Displasia

How would you rate your child's diet?____Well Balanced____Average____High sugar/processed food
Does your child consume artificial sweeteners? Y N
Number of hours your child sleeps: _____hours per night _____hours per day/naps
Sleep Quality: Good _____ Fair_____ Poor_____



Imagine this picture is your body. Can you color or circle the area that is hurting you right now? Please list anything else that is pertinent to your visit today:_____

_____

_____

I, _____the undersigning parent/guardian having legal custody/guardianship of_____, a minor, do hereby authorize, request and direct Results Chiropractic, Inc and their providers and whomever she might designate as assistant to preform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at P.O. Box 235, Beverly, Ohio 45715.

Patient:_____Signature:_____

Print Name Parent/Legal Guardian

Rev 01/2017

RESULTS CHIROPRACTIC INC.

YEARLY PATIENT UPDATE FORM

We thank you for your cooperation in keeping your records up-to-date.

TODAY'S DATE: _____

PATIENT NAME: _____ SSN: _____
(If you prefer not to provide your whole SSN, please provide the last four digits)

DATE OF BIRTH: _____ AGE: _____ Male___ Female___
Married___ Single___ Divorced___ Separated___ Other___

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____
CARRIER: _____ _____
(If you provide us with your cell phone number and/or home phone numbers, please provide us with the carrier's name, i.e. Verizon, AT&T, Sprint, etc. In providing this information, your signature below gives us permission to Text Message appointment reminders and other messages as may be appropriate.)

E-MAIL ADDRESS: _____
EMERGENCY CONTACT: _____ PHONE: _____

WORK PHONE: _____ (Permission to call? yes no)

EMPLOYER NAME: _____

ADDRESS: _____

PRIMARY PHYSICIAN NAME: _____ PHONE: _____

SPOUSE'S
NAME: _____ DOB: _____ SS# _____

SPOUSE'S EMPLOYER NAME: _____ Occupation: _____

ADDRESS: _____

PHONE: _____ (Permission to call? yes no)

PLEASE PROVIDE THE STAFF WITH YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE WHEN RETURNING THIS INFORMATION TO THE DESK. THANK YOU.

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE: _____

IF PATIENT IS A MINOR, YOUR NAME & RELATIONSHIP: _____

_____

Rev 11/01/2017

RESULTS CHIROPRACTIC INC.

A Family Wellness Center

JOHN S URBAN III DC, CCSP and LETTY L URBAN DC, DICCP

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing him/her/their, any and all records and reports, including x-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment, or opinion concerning that I may have had in the past, now have, or may have in the future.

Please forward all requested reports, x-rays and/or information to Results Chiropractic Inc. A copy of this release of information shall be as valid as the original.

_____
Signature

_____
Date of Birth

I give my permission to release information regarding myself to _____, which I may revoke in writing at any time.

_____
Signature

HIPPA

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 HIPPA NOTICE that is available to you at the front desk before signing this consent. If there should be anyone you do not want to receive your medical records, please inform our office staff.

By signing below I also release Results Chiropractic Inc. from any responsibility should I choose to engage in electronic exchange of information (texting, email, etc.) with any of the providers of service at Results Chiropractic Inc. regarding myself, minor, or other individual of which I have guardianship, ie, if such personal information is intercepted by anyone other than the mail recipient.

Patient's Signature _____ Date_____
Guardian's Signature Authorizing Care _____ Date_____
Initial here _____ if our office can use your name on our web site/newsletter.

Correspondence Address: P O Box 235 – Beverly OH 45715
Two Locations: 643A STRT 821 Bldg 4 - Marietta OH 45750 and 519 Fifth Street – Beverly OH 45715
(740) 678-2700
(740) 678-2777 FAX

RESULTS CHIROPRACTIC
A Family Wellness Center
John S. Urban III D.C.

Minor Consent Form

_____ has my permission to be treated without parental presence.

_____ _____
Signature (Parent or Guardian) Date

_____ _____
Witness Date

OFFICE USE ONLY

Vitals: *In EZnotes, complete by* 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ **Height:** _____ Weight: _____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:
Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

Timely access: *In EZnotes, complete by* 1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*" ☐ Completed?

Medications: *In EZnotes, complete by* 1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies" ☐ Completed?

Entered into EZnotes by (name): _____ Date & Time: _____

Results Chiropractic Inc: PHI Disclosure Log

Date	PHI Released	Recipient of PHI	Released by:

Rev 09/2013

Results Chiropractic Inc.

A Family Wellness Center

Terms of Acceptance/Informed Consent

When we accept you as a patient into our practice, it is important that you understand the objectives of our care.

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress in your body.)

A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause dis-ease or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxations by using specialized techniques (spinal adjustment.) When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural healing ability, your inner healer, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptoms(s) your body is expressing, you always need a body free from subluxations.

If, during the course of our chiropractic spinal examination, we encounter unusual findings, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them in your goals.

To summarize: the purpose of chiropractic care is not to treat the diseases or conditions, not to suppress symptoms, nor to perform surgery, but rather to make your body function better by removing spinal nerve stress (subluxations). Therefore we don not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

Our objective is to eliminate a major interference to the expression of your physical/emotional health and healing-vertebral subluxations – so that your natural healing ability and your inner healer may function without this severe form of stress.

Signature_____ Date_____