Arnold Chiropractic

Phone: (316) 794-2480

228 N. Main P.O. Box 643 Goddard, KS 67052

WELCOME

The doctor and staff of Arnold Chiropractic welcome you and want to provide your child with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Please print

Date ____________________

Child's Name______________________________________Address____________________________________

City _________________________State _____________Zip ________Home Phone ___________________

Child's Social Sec. #_____________ Child's Age _______ Child's Date of Birth __________ Sex M F

Height ____________Weight ___________Name of Parent(s)/Guardian(s) ____________________________

Parent/Guardian day number____________________________ Referred by_________________________

What insurance company will this case be covered by? ____

Insured's Name ________________________Insured's Social Sec. #__________________ Sex M F

Insured's Date of Birth ________________ Insured's Employer_____________________________________

Is any other member of your family being treated in this office? ____________________________________

How did you hear about this office?____

For what problem have you had chiropractic care before?____

Were the results satisfactory? Yes No N/A

Are you currently seeking: Consultation Chiropractic Adjustments Acupuncture Nutritional Guidance?

Child's Current Problem

What condition are you seeking help for? ____

How do you believe your problem (pain) began? ____

When did you first notice this problem/pain?____

What positions or activities aggravate the condition?____

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Child's Current Problem Continued

What positions or activities relieve the condition?____

When has your child ever had this condition before or a similar condition?______________________________

What other doctors has your child seen for this ailment?____

What treatment was recommended? ___________________________________Did it help?______________

Child's Health History

Family physician's name and address____

Has your child ever been in any accidents, auto, fall down stairs, fall from ladder, etc.?_________________

When & where?____

Is your child allergic to anything you are aware f?____

Has your child ever broken any bones? (fractures) ___________ Any dislocations? ___________________

What operations has your child had? ___________________________________Year ________________

___________________________________Year ________________

When was his/her last: Blood tests _________ Urinalysis________MRI ___________ CT Scan __________

Ultrasound_________ Radiation Treatment___________ X-Ray____________

Does (s)he have any health problem the doctor should be aware of? ____________________________________

Does (s)he faint easily? ______ Have they lost weight in the past year? ________________________________

What conditions has your child been treated for by a physician in the past year? _________________________

____

What medications, herbs, vitamins or over the counter products (aspirin included) is (s)he presently taking (or the child's mother if breast feeding)?

____

Circle any of the following that your child now experiences or has experienced in the past:

ADD/ADHD	Asthma/Allergies	Back Pains	Bed Wetting	Chronic Colds	Colic	Constipation
Diarrhea	Digestive Problems	Ear infections	Growing Pains	Headaches	Neck Pains	
Scoliosis	Seizures	Sinus Troubles	Skin Problems	Recurring Fevers	Temper Tantrums	
Vaccinations	Vaccination Reaction					

Child's Personal Habits:

How much does (s)he drink of: Water:_______ Soda: _________ Juice:__________ Milk: __________

Formula:_________ Other: _______________

Does your child get enough exercise regularly? Yes No What kind of exercise? _______________________

Hobbies _____________________________________

Use this space for any concerns you may wish to discuss ____

____

____

____

Patient Name______________________

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Mother's History:
While pregnant with this patient did you experience: Ankle Swelling, High Blood Pressure, Morning sickness
Did you require bed rest with this pregnancy? Y N For what condition?______________________________
Use of medications (prescription or over the counter):____
Length of Labor:__________ Any medications used during labor or delivery?__________________________
Place of Delivery:_________________________ Delivering Midwife/Doctor____________________________
Any of the following used during delivery: C-Section, Episiotomy, Epidural, Forceps, Pain Medication, Spinal Block, Vacuum Extractor
Any complications after delivery?______________________ How long was the child breast feed?___________
Habits of Parents/Guardians:
Do you use: Chewing tobacco/Cigarettes ______ Quantity _______ Do you exercise regularly? Yes No
What kind of exercise? _______________________ Hobbies ______________________________________

PRIVACY STATEMENT
I understand that all health information disclosed in this office is kept strictly confidential and will not be released to anyone with out my consent. By signing below, I agree to allow Arnold Chiropractic to provide all needed information to the doctors of this office, the chiropractic radiologist who may be called on for expert consultation on my x-rays, as well as my insurance carrier.

ACCEPTANCE AS PATIENT
By signing below, I understand and agree that the doctor of Arnold Chiropractic has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Nutritional Guidance
By signing below, I understand that the suggested nutritional program is not intended as a treatment for any disease. This adjunctive schedule of nutrients is provided with the intent of supporting the physiological and biochemical processes of the human body, and not to diagnose, treat, cure, or prevent any disease or condition.

Insurance Assignment of Benefits
By signing below, I authorize my insurance carrier(s)/Medicare/Medigap to submit payment directly to Arnold Chiropractic for all claims filed on my behalf by this office.

_____________________ _______________________________
Date Signature of patient/guardian

Please note: **during adverse weather conditions, the Office will be closed if Goddard schools are closed.

Patient Name______________________