Welcome to Revelation Chiropractic!
Our mission in this office is to educate and inspire others to live healthier lives through chiropractic.
In order to best serve you, please take the time needed to fill out these forms completely.

Child's Name: _____ Date:_____

Mother's Name: _____ Father's Name: _____

Address: _____City: _____ State: _____Zip: _____

Home Phone: _____ E-mail: _____

Date of Birth: _____ Age: _____ Sex: M F SSN: _____

Number of Siblings: _____ If you were referred to our office, whom may we thank?_____

PLEASE READ: The purpose of today's visit is to see if chiropractic can help your child. Your child's file will be carefully analyzed and you will receive a personalized report of findings.
The fee for today's examination is $50 (unless special arrangements have been previously discussed) and will be due today.

PLEASE INITIAL HERE indicating that you have read and understand this section: _____

PURPOSE OF TODAY'S VISIT
Because chiropractic focuses on function and not disease, your child (and the rest of your family) does not need to have symptoms to benefit from care. Please indicate the reason for your child's visit today:

☐ Spinal screening and wellness check

☐ Accident or Fall. Please describe_____

☐ Illness or other health problem. Please describe_____

Have other doctors/therapists been consulted for this condition? ☐ Yes ☐ No
If yes, who? _____

Has your child ever been checked by a Doctor of Chiropractic? ☐ Yes ☐ No Date of last visit_____

Name of Doctor seen: _____

CURRENT AND PAST HEALTH HISTORY

Has your child experienced any falls, accidents or traumas? ☐ Yes ☐ No
Please describe: _____

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other_____

Provider: ☐ Midwife ☐ Ob-Gyn ☐ Other Provider's Name: _____

Type of birth: ☐ Vaginal ☐C-section ☐ Breech

Was anesthesia used? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No If yes, why? _____

Were other medications used? ☐ Yes ☐ No If yes, why?_____

Birth trauma: ☐ Doctor assisted ☐ Forceps ☐ Vacuum extraction ☐ Twisting/Pulling

APGAR Scores: ____ , ____

Was your child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Does your child have any food intolerances? ☐ Yes ☐ No If yes, what? _____

How would you rate your child's diet? ☐Good ☐Average ☐Poor

Please indicate any of the following your child has suffered with:

☐ Colic
☐ Irregular sleeping patterns
☐ Night terrors
☐ Seizures
☐ Tantrums
☐ Eczema
☐ Ear infections
☐ Allergies
☐ Asthma
☐ Headaches
☐ Poor digestion
☐ Repeated infections/colds
☐ Bed Wetting
☐ Learning disorders
☐ ADD or ADHD
☐ Digestive disorders
☐ Constipation
☐ Diarrhea
☐ Growing pains
☐ Backaches
☐ Broken bones
☐ Other _____

Does your child play any sports? If so, please list: _____

Does your child sit for extended periods of time in front of a computer or TV? ☐ Yes ☐ No # Hours: _____

Is your child currently taking (or has taken) any medications? ☐ Yes ☐ No Please list:_____

_____

Has your child had any surgery? ☐ Yes ☐ No Please list: _____

Has your child been vaccinated? ☐ Yes ☐ No

☐ Routine ☐ Delayed ☐ Other Explain:_____

Authorization for care of a minor:
I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter.

Signature: _____ Witnessed: _____ Date: _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Signature: _____ Date: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely check by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to…

_____ Respond to Sound	_____ Stand Alone
_____ Respond to Visual Stimuli	_____ Walk Alone
_____ Hold Head Up	_____ Vocabulary of ≥ 20 Words
_____ Sit Up on Their Own	_____ Speak in ≥ 3 Word Sentences
_____ Cross Crawl	

For Office use ONLY

REFLEX	FULL	PARTIAL	ABSENT	DURATION
Babinski				Stops at 9-12 months
Rooting				Stops at 3-4 months
Moro				Stops at 3-4 months
Gallant				Stops at 3-9 months
ATNR				Stops at 6 months
Total:				

REFLEX	FULL	PARTIAL	ABSENT	DURATION
Stepping				Stops at 3-4 months
Landau				4th to 12th months
Parachute				In place by 10 months
Total:				

Reflex tests are simple physical tests of nervous system function. A reflex is a simple nerve circuit. A stimulus, such as a light tap with a rubber hammer, causes sensory neurons (nerve cells) to send signals to the spinal cord. Here, the signals are conveyed both to the brain and to nerves that control muscles affected by the stimulus. Without any brain intervention, these muscles may respond to an appropriate stimulus by contracting. Reflex tests help to assess the integrity of the nerve circuits involved. Reflex tests are performed as part of the neurological exam.

Revelation Chiropractic, LLC
INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but in this office the adjustment is made gently by hand or instrument. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic care may include soreness or bruising.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative options have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE *REVLEATION CHIROPRACTIC, L.L.C.* TO PROCEED WITH CHIROPRACTIC CARE.

_____	_____	_____
Patient Signature	**Team Member Signature**	**Date**

Parental Consent for Minor:

Minor Name: _____
Minor age: _____ DOB: _____
Printed name of person legally authorized to sign for Minor: _____
Signature: _____
Relationship to Minor: _____

In addition, by signing below, I give permission for the above named minor to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Minor: _____
Signature: _____
Relationship to Minor: _____

Your Personal Privacy is Very Important to Us!

In this day and age it is unfortunately very easy for people to have their personal and private information shared without their knowledge or consent. Because your privacy is so important to us, we have taken steps to ensure that we will never share your personal or private information with anyone except to assist you in getting reimbursed from a third party or in helping you keep on track with your schedule of care and in moving progressively toward the results you desire and deserve.

We may only disclose any information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you. This request must also be accompanied by a consent form signed by you.
- To an insurance carrier, HMO or employer if they are possibly responsible for payment or reimbursement of services. This request must also be accompanied by a consent form signed by you.
- We may ask your permission to use you as a success story to help others see the value of care in our center. We will ask for you to sign a separate consent form if this is the case.
- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you a reminder by Email.
- Adjustments will be performed in an open adjusting environment. It may be possible that other people in the office may overhear some protected health information during the course of care. Should you need to speak with the doctor at any time in private, a time must be scheduled separately for these conversations.
- We reserve the right to alter/amend the terms of this privacy notice. If changes are made to our privacy policies, we will send you a notice by Email and post the policy changes in our center where they are easily visible for all of our practice members to view.
- If you have a complaint regarding any aspect of our privacy policies, or if you would like further information about them, please contact Dr. Jennifer Minnich.

My signature acknowledges that I have read this notice, I understand it and I hereby agree to comply with the policies as explained here.

New Patient Name (Please Print) _____

New Patient Signature _____ Date ___/____/____

Parent/Guardian Name (if under 18) _____

Parent/Guardian Signature _____ Date ___/____/____