



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 \$60** (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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Colic                       | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Irregular sleeping patterns | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Night terrors               | <input type="checkbox"/> Poor digestion            | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Repeated infections/colds | <input type="checkbox"/> Backaches     |
| <input type="checkbox"/> Tantrums                    | <input type="checkbox"/> Bed Wetting               | <input type="checkbox"/> Broken bones  |
| <input type="checkbox"/> Eczema                      | <input type="checkbox"/> Learning disorders        | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Ear infections              | <input type="checkbox"/> ADD or ADHD               |  |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Digestive disorders       |  |

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 $\geq 20$ Words
_____ Sit Up on Their Own	_____ Speak in $\geq 3$ 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*  
HEALTH CARE AUTHORIZATION FORM

***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 \_\_\_ / \_\_\_ / \_\_\_