COMPASS
CHIROPRACTIC

At our office, we have one simple goal. We want to change your life by rendering the highest quality chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your God given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions, please feel free to ask us.

1. **Your Initial Examination:** In your first visit, you will have an initial consultation with the doctor. This is usually preceded by a chiropractic examination including nerve systems scans and spinal x-rays if warranted and appropriate. Your first Chiropractic adjustment is included in this visit.
2. **Your Report of Findings and Care Plan:** On your second visit to our office, the doctor will discuss your scans and x-rays with you to establish a schedule of visits to address your main complaint. Once the outward signs of this problem have been addressed, the obvious question is, "Would you be willing to take the additional steps that would be necessary to strengthen and stabilize your health so that the problem that caused you to consult us would be far less likely to return?" Our long-term goal is to help you navigate life's stress and strain on your nervous system and to maintain the health gains achieved through your initial phase of care. We call this wellness care in our office. These visits are less frequent than the acute phase and focus on prevention. Our wellness care patients consult with us regularly about which lifestyle strategies could be employed to cause their health to improve year after year.

Child Health Form

To be filled out by parent or guardian. Please print clearly and fill in completely.

Print Child's Name_____ **Date of Birth**_____

Street Address _____ **Apt.#** _____

City _____ **State** _____**Zip**_____ **Phone** _____

Email_____ _____ Sex: Male❑ Female❑

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long your child has had them: _____

_____

Is the child under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates:_____

List any x-rays you've had in the past 2 years: _____

Referrals

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know who referred you, ***or*** where you heard about our office? _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes, Doctor's Name _____

Date of last chiropractic visit _____Reason for care_____

Date of last chiropractic x-rays _____How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who?_____

Prenatal History

Duration of gestation _____ weeks? Pregnancy normal? Y__ N__ Tobacco/Alcohol use? Y__ N__

List any significant complications during pregnancy:

_____

Location of Birth: Hospital __ Birthing Center__ Home__ Length of labor __ hrs.
Drugs used during deliver? Y__ N__ Birth Intervention: Forceps__ Vacuum Extraction__
C=Section __ Was it an Emergency___ or Planned___?
List any medications taken during pregnancy:_____
Apgar score at birth:_____ Apgar score at 5 min._____ Birth Weight____ Length_____

Nutritional History

Breastfed___ months___Formula began at age___for___months. Began solid foods at _____months.

Childhood Disease:

Chickenpox	Y N	Age____	Rubella	Y N	Age____	Mumps	Y N	Age____
Rubeola	Y N	Age____	Measles	Y N	Age____	Whooping Cough	Y N	Age____

Trauma

Fall/Jump from a height of < 3 feet	__Yes __No	Inhaler Use	__Yes __No
Car Accident	__Yes __No	Surgery	__Yes __No
Childhood Illness	__Yes __No	Youth Sports	__Yes __No
Repeated Prolonged Antibiotics	__Yes __No	Vaccination	__Yes __No

Any significant falls, accidents, or surgeries as a child? Please list:

1._____Date:_____

2._____Date:_____

3._____Date:_____

Rate Your Child's Overall Health

At Compass Chiropractic we are dedicated to achieving lasting health for each of our practice members. To better help you achieve this; we need to understand how you view your child's overall health. Based on a scale of 10% to 100%, please **circle** what you feel is your child's current level of health and wellness.

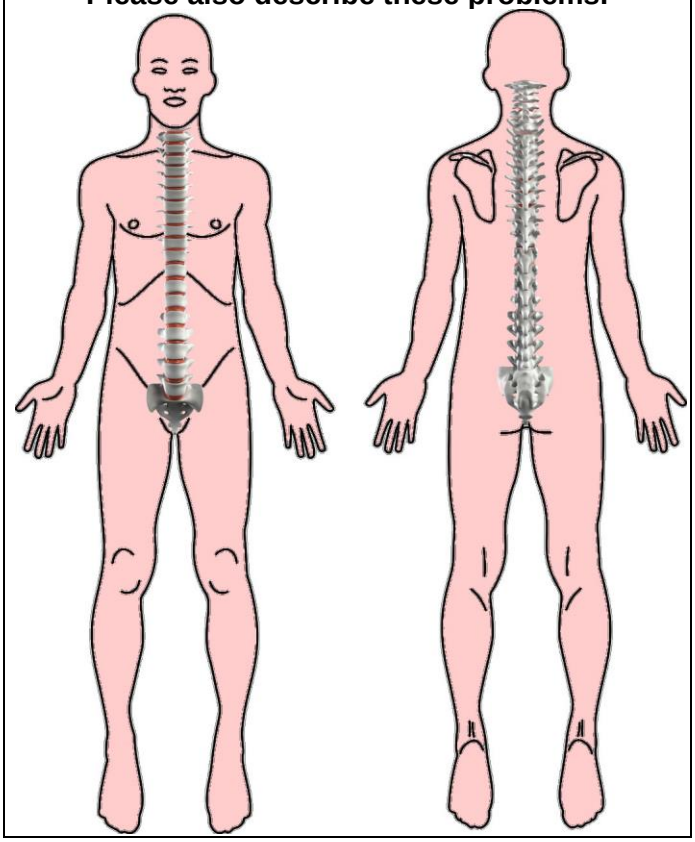
10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Please Fill in Below

Has your child suffered from the following within the past year? *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Muscle pain	❑	❑
Growing pains	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Ear infections	❑	❑
Earaches	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Frequent colds	❑	❑
Bed Wetting	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
ADHD	❑	❑
Hyperactivity	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Colic	❑	❑
Digestive problem	❑	❑
Skin conditions	❑	❑
Learning Disabilities	❑	❑

Circle the areas where your child has any pain or health problems.
Please also describe these problems.



Have you had this condition before? ☐ Y ☐ N

What originally started this condition?

_____

If you have pain associated with your condition, how would you describe it? Check all that apply.

☐ Sharp ☐ Constant ☐ Localized ☐ Radiating
☐ Pins & Needles ☐ Dull ☐ Numbness
☐ Burning ☐ Comes & Goes

Is there any time of the day or any activity that makes your condition worse?

_____

Better?

_____

Any other concerns or health information you feel we may need to be aware of for your care?

_____

_____

Privacy and Informed Consent

Notice of Open Adjusting Policy

I consent to initiate care in the form of an examination, nerve scans, and, if needed, x-rays at Compass Chiropractic. This office provides care in an "open-door/open adjusting" environment. This involves several patients being seen in the same adjusting room at the same time. This format is for routine care, NOT for patient histories or exams. These procedures are completed in a private, confidential setting. Your signature below constitutes authorization for "incidental disclosure" of health information that could occur in this format. This is intended to make our office more efficient and enhances your access to quality health care. If you have any concerns, other arrangements can be made.

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. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES 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 or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

As the Parent/Legal Guardian of _____ I authorize Leroy Dickman II, DC to administer care as he deems necessary to my son/daughter.

Patient name _____ **Date**_____

Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature_____