WELL ADJUSTED CHIROPRACTIC
CHIROPRACTIC CARE FOR ALL AGES AND STAGES
WELLADJUSTED4ALL.COM

502 N 1st Street, Silverton, OR 97381

Phone: (503) 420 - 8272
Fax: 1 (503) 200 -1347

Patient Information

First Name:_____ **Middle:**_____**Last Name:** _____

Date of Birth:_____ **Age:** _____ **Gender***(check one)*❑Male❑Female❑Unspecified

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Parent A

Name: _____

Primary Phone:_____

Mobile Phone: _____

Contact Method (check one)

□ Primary Phone □ Mobile Phone □ Email

Email: _____

❑ Opt out of Marketing via Email

Parent B

Name: _____

Primary Phone:_____

Mobile Phone: _____

Contact Method (check one)

□ Primary Phone □ Mobile Phone □ Email

Email: _____

❑ Opt out of Marketing via Email

Referral Information

Who can we thank for telling you about us? _____

Social Media: ❑Facebook ❑Instagram ❑Google ❑ Other: _____

Medical Provider

Primary Care Physician: _____ Last Visit: _____

How long have you been with this Physician? _____

Reason for Visit

What concerns do you feel Well Adjusted Chiropractic can help your child with?

_____

—

_____

—

Please indicate below how these concerns are affecting your child's everyday life?

□Walking □Playing □Sleep □Attention/Focus □Communication

□Eating/Nursing □Daily Routine □Other:

Has your child ever received Chiropractic Care? □Yes □No **If yes, was it a good experience?** □Yes □No

Reason for previous Chiropractic Care: _____

Why was care stopped? _____

How long? _____ **Date of last visit:** _____

Have you consulted or do you regularly consult any of the providers below for your child?

❑ Medical Doctor ❑Naturopath ❑Acupuncture ❑Physical Therapist ❑Counselor ❑Psychotherapist

❑ Craniosacral Therapist ❑Other: _____

Pregnancy

During pregnancy did the mother experience an illnesses, difficulties, or trauma? □Yes □No

If yes, please explain:

_____

_____

Did mother receive Chiropractic Care: □Yes □No

Was the delivery premature? □Yes □No **If yes, how many weeks early?** _____

Approximately how long did labor last? _____ **hours**

Was labor artificially induced? □Yes □No

Was the child in a breech position (butt down) or otherwise mis-positioned? □Yes □No

What position was the child in? _____

Where was the child born?

□Hospital □Home Birth □Birth Center □Other: _____

How was the child born? □ Vaginal □C-section

Were any of the following administered during labor and birth?

□Water Birth □Vacuum □Forceps □Epidural □Medications _____

Please check all that apply to the child's statue immediately after birth: APGAR Score _____

□ Jaundice □ Respiratory Problems □ Broken Bones: _____

□ Nursing Difficulty □ Displaced joints □ Other Conditions: _____

Health History

Have you consulted or do you regularly consult any of the providers below?

❑ Medical Doctor ❑Naturopath ❑ Craniosacral Therapist ❑Other: _____

Is the child breastfed? □Yes □No

If no, when was breastfeeding stopped? _____

How many hours does the child sleep at a time? _____

Does the child experience:

□ Frequent Urination □ Constipation □ Colic □ Teething □ Coughing □ Ear pulling

□ Congestion □ Redness on the skin □ Baby acne □ Frequent spit up □ Gassy

Has the child had any surgeries? ❑Yes ❑No

If yes, please describe (please include surgery name and date if possible): _____

_____

_____

Have any of the following milestones been met? *(Check all that apply)*

□Calms down when spoken to or picked up □Looks at your face □Seems happy to see you when approaching

□Smiles when you talk / smile □Makes sounds other than crying □ Turns head toward sounds

□ Pays attention to faces □ Can hold head up while on tummy □ Opens hands briefly

□ Chuckles □ Babbling / Cooing □ Reaches for toys w/ one hand

□Looks at you, moves or makes sounds to get attention □ Holds head steady when pick up

□ Holds toy when placed in their hand □ Brings hands to mouth □ Pushes up onto elbows / forearms

□ Knows familiar people □ Likes to look at self in mirror □ Laughs

□ Rolling over (both directions) □Pushes up with straight arms when on tummy □ Sitting without support

□Crawling □ Shy around strangers □ Facial expressions

□ Looks when name is called □ Reacts when you leave (crying, etc) □ Lifts arms to be picked up

□ Looks for objects when dropped out of sight □ Says words like “Mama” or “Dada”

□ Lifts arms to be picked up □ Uses fingers to “rake” food towards them

□ Moves objects from one hand to the other □Waves Bye-Bye □ Understands “No” □ Pulls up to stand

□ Walks holding onto furniture □ Drinks from a cup w/out lid □ Picks things up w. pointer finger and thumb

What are your expectations from Chiropractic Care

❑ Relief of a symptom or problem ❑Healthier Spine and nervous system

❑Relief and Prevention of a symptom or problem ❑ Healthier lifestyle

❑Optimal Health on all levels ❑Other: _____

Authorization

I certify that I, _____ (circle one: the parent or legal guardian of _____), have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon treatment, upon suspension or termination of my care or treatment. I have read the Well Adjusted Chiropractic LLC Notice of Privacy Practices sheet that was offered to me at my first appointment.

- ❑ By checking this box, I request a copy of Well Adjusted Chiropractic LLC Notice of Privacy Practice.

Patient's Name: _____ Parent / Guardian Name: _____

Parent / Guardian Signature:_____ Date: _____

WELL ADJUSTED CHIROPRACTIC
CHIROPRACTIC CARE FOR ALL AGES AND STAGES
WELLADJUSTED4ALL.COM

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Alternatives to Chiropractic Care: Chiropractic adjustments aren't the only treatment options you have. The doctor may refer you for massage therapy, physical therapy, acupuncture or may not provide an adjustment at all, if one is not needed. The doctor may prescribe another treatment such as in office modalities like cupping, instrument assisted soft tissue mobilization tools, manual mobilization, electrical stimulation, ice or heat.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or bruising of the skin.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name (Parent / Guardian)	**Signature (Parent /Guardian)**	**Date**

Pt:

Date:

WELL ADJUSTED CHIROPRACTIC
CHIROPRACTIC CARE FOR ALL AGES AND STAGES
WELLADJUSTED4ALL.COM

502 N 1st Street, Silverton, OR 97381

Phone: (503) 420 - 8272
Fax: 1 (503) 200 -1347

Cancellation/No Show Policy

We understand that there are times when you must cancel an appointment due to emergencies or other obligations such as work, family, etc. When you do not call to cancel an appointment, you may be preventing another patient from being seen. Conversely, the situation can also occur where another patient fails to cancel and we are unable to schedule you for a visit, due to a "full" schedule. We ask that all patients be respectful and mindful of their appointments to make sure everyone is getting the care they need in a timely manner. We have recently installed an appointment reminder service that will assist by sending reminders of your appointment.

If you need to cancel, please call or text us **24 hours ahead of your scheduled time**.

If you do not show up for your scheduled appointment, we will waive the our No-Show fee because we understand that situations happen. If it happens a second time, **we will charge you a $35 No-Show fee** to make up for the lost appointment where someone else could have been scheduled.

We understand life happens at a fast pace and there may be some instances where you cannot notify us ahead of time. Please provide proper documentation, such as doctor's note/discharge papers or proof of the reason you were unable to contact us ahead of time.

Late Policy

We understand and respect your schedule and your time, but we also respect the time of our other patients. We often have a full schedule and Dr. Brymer would like to stay on time as much as possible to make sure every patient gets the care they need. We will give each patient a **10 minute grace period**. If you have missed this period, we will consider this a cancellation / no show and you will receive a will be notified of your missed appointment and be rescheduled for another day. If you know you are running late, please call or text our office to let us know. We will accommodate you the best we can.

☐ I have read the Cancellation/No Show and Late policy

☐ I understand the Cancellation/No Show and Late Policy

Printed Name Patient **Signature of Patient/Guardian** **Date**