

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 **Parent B**

Name: _____ Name: _____

Primary Phone: _____ Primary Phone: _____

Mobile Phone: _____ Mobile Phone: _____

Contact Method (check one) **Contact Method** (check one)

Primary Phone Mobile Phone Email Primary Phone Mobile Phone Email

Email: _____ Email: _____

Opt out of Marketing via 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?

<input type="checkbox"/> School	<input type="checkbox"/> Exercise/Sports	<input type="checkbox"/> Walking	<input type="checkbox"/> Playing
<input type="checkbox"/> Attention/Focus	<input type="checkbox"/> Communication	<input type="checkbox"/> Eating/Nursing	<input type="checkbox"/> Daily Routine
		<input type="checkbox"/> Sleep	
		<input type="checkbox"/> 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 and Birth

During pregnancy did the mother:

Experience and illnesses, difficulties, or trauma? Yes No If yes, please explain:

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 status immediately after birth: APGAR Score _____

Jaundice Respiratory Problems Broken Bones: _____

Nursing Difficulty Displaced joints Other Conditions: _____

Was the child breastfed? Yes No For how long? _____

Physical Stress: Infancy and Childhood

Please check all that apply to your child and give any necessary details:

<input type="checkbox"/> Uncoordinated / Accident prone	<input type="checkbox"/> Has been hospitalized
<input type="checkbox"/> Had a severe trauma or concussion	<input type="checkbox"/> Been in an automobile accident
<input type="checkbox"/> Has fractured a bone or dislocated a joint	<input type="checkbox"/> Has / Had chronic illness
<input type="checkbox"/> Has had surgery	<input type="checkbox"/> Other: _____

Did your child successfully complete any of the following:

<input type="checkbox"/> Tummy Time for at least 15 minutes per day	<input type="checkbox"/> Rolled over from back to stomach (both directions)
<input type="checkbox"/> Sat up unassisted	<input type="checkbox"/> Crawled on all fours (not one leg hiked up)

Does your child have any of the following:

Asthma Toe Walking Allergies Bedwetting Constipation Food aversion Stuttering

What activity level does your child have?

Active Sports Plays at School Plays outside Sedentary

Eating Habits:

Eats a well balanced diet Picky Eater Grazer (Small amounts over the course of the day)

Other: _____

Sleeping Habits:

Sleeps soundly Active sleeper (moves a lot in sleep) Night Terrors / Nightmares Insomnia

Not easily woken in the morning Other: _____

Interests / Hobbies:

Sports Video Games Movies Music Bike Riding Hiking Reading Writing

Art Drawing Pets Skateboarding Horseback riding Motocross

Other: _____

Emotional Stress**Have there been any recent changes in behavior?**

Increased tantrums Lethargic Loss of appetite Increased appetite

Change in sleep pattern Emotional outbursts Other: _____

Please indicate if your child has ever or is currently experiencing any of the emotional stresses below: (Check all that apply)

Academic pressure Loss of a loved one Bullying Relocation

Lifestyle change Parents' divorce Loss of pet New sibling

Does your child have difficulty interacting with schoolmates or friends? Yes No**Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?**

Yes No

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.

Printed Name of Patient: _____ Printed Name of Guardian: _____

Signature of Patient or Guardian: _____ Date: _____



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 a 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 hereby give my full consent to treatment.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date



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