LIFE IN MOTION Chiropractic Center

lifeinmotionchirocenter.com

Dr. Nathaniel Reese
Dr. Elizabeth Smolick-Reese

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Phone: 727-745-1533
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Pediatric

Infants & Toddlers

Practice Member Information

File _____

Child's Name: _____ M _____ D _____ Y _____
Parent's/Guardian's Names: _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
How did you hear about us? _____
Height (of child): _____ Weight (of child): _____ Birth Date: M ____ D ____ Y _____ Age: ____ Sex: ☐ M ☐ F
Siblings and ages: _____ _____ _____ _____
Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to child: _____
Phone number: _____ Alternate phone number: _____

Family Doctor

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your fami y doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

☐ He/She is continuing ongoing care from another chiropractor.
☐ I recently had my spine checked and understand the value in getting my child checked.
☐ I have concerns about his/her hea th and I'm looking for answers.
☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called ***vertebrae.*** Many of the common health challenges that adults experience have their origins during the ***developmental years,*** some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins and emotional stress.*** The result may be misalignment to the spinal column and damage to the nervous system in a condition called ***Vertebral Subluxation.*** Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal.***

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivites	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PDD

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint?

☐ No ☐ if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? . . . . . ☐ No ☐ Yes _____

Has your child ever experienced this complaint before? . . . . . ☐ No ☐ Yes _____

Did they receive any treatment at the time? . . . . . ☐ No ☐ Yes _____

Has your child had x-rays in relation to the current complaint? . . ☐ No ☐ Yes _____

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (Brief description) _____

Ultrasounds during pregnancy: ☐ No ☐ Yes If so, how many? _____

Medications during pregnancy: ☐ No ☐ Yes _____

If so, which ones and how often? (include OTC): _____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ No ☐ Yes _____

Birth Experience

Location of Birth: ☐Home ☐Hospital ☐ Birthing Centre ☐Other _____
Birth Attendants: ☐Doula ☐Midwife ☐GP ☐OB ☐Other _____
Medications during labor / delivery? (including IV antibiotics) ☐No ☐ Yes _____
Was Pitocin used to induce / speed up labor: ☐No ☐Yes
Were your membranes ruptured by a medical professional? ☐No ☐ Yes
Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐No ☐Yes ☐Unsure
If yes, please describe: ☐Breech ☐Transverse ☐Face / Brow presentation
Was your delivery vaginal or C-sect on? _____ If it was a C-section, was it planned or emergency? _____
If it was vaginal, was the baby presented: ☐Head ☐Face ☐Breech
Were any of the following interventions used during delivery? ☐Forceps ☐Vacuum Extraction ☐Other
Were there any complications during delivery? ☐No ☐Yes
If yes, please specify: _____
How long was the labor from the first regular contractions to the birth? _____ Hours
How long was the second stage (the pushing phase) of the labor? _____ Hours
Was the baby born with any purple markings / bruising on their face or head? ☐No ☐Yes
Any concerns about misshapen head at birth? ☐No ☐Yes

Post Natal History

How many weeks gestation was the baby at birth? ___w ___d / Birth Weight: ___lbs___oz / Birth Length: _____Inches
If known, APGAR scores at: 1 minute_____/10 5 minutes _____/10
Was the baby ever administered to Neonatal Intensive Care? ☐No ☐ Yes
If yes, for how long and why? _____
Was any medication given to the baby at birth? ☐Yes ☐No ☐Unsure
If yes, what medication and why? _____

Child Health History *(Answer only those which are applicable)*

How many hours does your baby sleep between feedings? _____ Day _____Night
Does your child have a preferred sleeping position? ☐No ☐ Yes _____
Does your child have any feeding difficulties? ☐No ☐Yes _____
Is your child currently being breast fed? ☐Yes: exclusively breastfed ☐formula supplemented ☐No
If no, how long was the baby breast fed? _____ weeks/months
Does your child have a one-sided breast preference? ☐No ☐Yes If yes, Prefer Left or Right _____
Does your child frequently spit up after feeding? ☐No ☐Yes
Does your child cry often? ☐No ☐Yes If yes, approximately how many hours per day? _____
Does your child pass a lot of intestinal gas? ☐No ☐Yes
Does your child frequently arch his/her head and neck backwards? ☐No ☐Yes
Has your child shown any sensitivities to foods either in your diet or their own? ☐No ☐Yes _____
Is your child exposed to cow's milk/dairy? ☐No ☐Yes, formula ☐Yes, directly ☐Yes, I drink it and breastfeed.

Developmental History

Has your child ever fallen from any high places? . . . . . ☐No ☐Yes_____
Has your child ever been involved in a motor vehicle accident or near miss? . . . . . ☐No ☐Yes_____
Has your child been seen on an emergency basis? . . . . . ☐No ☐Yes_____
Has your child broken any bones? . . . . . ☐No ☐Yes_____
Has your child had any previous hospitalizations? . . . . . ☐No ☐Yes_____
Has your child had any previous surgeries? . . . . . ☐No ☐Yes_____

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule
Reason for vaccination: ☐Informed decision ☐Didn't know I had a choice ☐It was recommended
Reaction(s) to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue ☐Prolonged Cry
☐Seizures ☐Developmental Regression ☐Other _____
Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)
Has your child been exposed to antibiotics? ☐No ☐Yes
If yes, how many doses in past 6 months? _____ Reason _____
Were probiotics used at the same time as antibiotics? ☐No ☐Yes
Has your child been exposed to medications, including OTC: ☐No ☐Yes
If yes, which ones? _____
If yes, how many doses in past 6 months? _____ Reason _____
How many glasses of water/day does your child have? . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and soda/day does your child have? . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Does your child eat gluten? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ☐No ☐Yes If yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐No ☐Yes
Does your child follow any other dietary restrictions? ☐No ☐Yes _____
Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes _____
Is your child exposed to second hand smoke? ☐No ☐Yes _____
Does your child take a probiotic daily? ☐No ☐Yes: _____ CFU's/day
Does your child take vitamin D3 daily? ☐No ☐Yes: _____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐No ☐Yes: _____mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age:
Intellectually: ☐Yes ☐No _____
Emotionally: ☐Yes ☐No _____
Physically: ☐Yes ☐No _____

What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I _____ being the parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date

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FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE: **This includes all applicable office charges, coinsurance, deductible and copayments for participating insurance companies.** After 30 days of non-payment, a **$1.50 late payment charge** will be applied to your account, and an additional charge will be added every 30 days. The office accepts cash, personal checks (there is a service charge of $25.00 for returned checks), VISA, MasterCard and Discover. This office utilizes e-Pay – electronic statements send through email and/or text messages. By consenting to our financial policy, you are giving Life in Motion Chiropractic consent to send balances due via e-Pay.

We bill participating insurance companies as a courtesy to you. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible for all services not covered by your insurance carrier.

We do not bill all secondary insurance companies; primary and secondary must be linked electronically to bill. Please check with your insurance company to verify. Patients will be responsible for charges not billed to your secondary insurance. Your time of service receipt includes all information necessary for you to submit claims to your insurance company.

MANAGED CARE: Some insurance companies require authorizations for chiropractic care. All visits not covered by lack of an authorization or denied by your insurance, for any reason will then become the responsibility of the patient. Please contact your insurance company for details pertaining to your insurances Prior Authorization guidelines. If your insurance denies your authorization for any reason the balance due will be the responsibility of the patient. **An insurance card does not guarantee payment, any changes made to your policy needs to be addressed at your visit.**

MEDICARE, MEDICAID, UPMC for You and UPMC for Life plans do not cover all chiropractic services. Office visit examinations and in office x-rays are not covered.

Auto and Work related charges will be billed to your insurance carrier, if for any reason claims are returned or denied, the balance due will become the patient's responsibility. Life in Motion will not be responsible for any misinformation given on patient's insurance coverage by the insurance companies or patient. **Once Auto/Worker Comp. medical benefit limits have been maxed out the patient will be liable for the balance remaining. Please be aware of your medical payment limits when scheduling your appointments.**

Missed Appointments/Late Cancellations: Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

No Show Policy: If New Patient and/or Second Visit (ROF) is not cancelled and rescheduled prior to the appointment (No Show), a $30.00 charge will be billed to your account.

I have read and understand the **Life in Motion Chiropractic's** Financial Policy. I agree to assign insurance benefits to Life in Motion Chiropractic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed. I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured/authorized representative: _____ Date: _____

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PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA FORM)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent from stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient understands that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts know to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known, is in my best interest and that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures and also give consent for chiropractic care.

Signature of Patient Date

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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name:_____ DOB: _____/_____/_____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.
This information may be released to:

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number:_____
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is:
Day:_____ Between (time):_____

Signed:_____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____

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INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the Patient: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed.*

I/We hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Dr. Nathaniel A. Reese, Dr. Elizabeth E. Smolick-Reese, or any other licensed Doctors of Chiropractic who may be employed by or engaged in practice at Life in Motion Chiropractic Center.

I have had an opportunity to discuss with Dr. Nathaniel Reese, Dr. Elizabeth Smolick-Reese and other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgements based upon the facts known to the doctor at the time, that is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgement, that no one guarantee as to results has been made nor relied upon by me, and I wish to rely on the Doctor of Chiropractic to exercise judgement during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interest.

I have also been advised that there are other rare risks, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the named procedures.

_____ _____

Patient's Name Parent/Guardian Signature

_____

Patient's Signature

_____

Witness

_____

Date

Doctor's Notes

Discussion: _____

Other: _____

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CONSENT TO TREAT OF MINOR CHILD

I/We hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Nathaniel A. Reese, DC and/or Elizabeth E. Smolick-Reese, DC, and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my _____(relationship of child).

I/We have had an opportunity to discuss with Dr. Nathaniel Reese and/or Dr. Elizabeth Smolick-Reese and other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known, is in my best interest.

I have also been advised that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree to the named procedures.

Dated at Canonsburg, Pennsylvania this _____ day of _____, 20____.

Signature: _____

Printed Name: _____

Witnessed: _____

Printed Witnessed Name: _____