Lark Chiropractic

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for your family.

(Please Print)

Patient Name:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Date of Birth: ____/____/____ S.S.#_____-____-_____ Gender: □ Female □ Male Height:_____ Weight:_____

Parent(s)/Guardian Name(s): _____ Referred By:_____

Purpose for Contacting Us? _____

Have Other Doctors Been Seen for this Condition? □ Yes □ No If Yes, List Doctor Name(s) and Prior Treatments:

_____

_____

Any Other Health Problems?_____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

□ Ear Infections	□ Digestive Problems	□ Car Accident	□ Headaches
□ Asthma / Allergies	□ Bed Wetting	□ Chronic Colds	□ Growing / Back Pains
□ Colic	□ Seizures	□ Recurring Fevers	□ Autism
□ Scoliosis	□ ADD/ADHD	□ Temper Tantrums	□ Other:_____

Family History:_____

Previous Chiropractor (If Any):_____ Date of Last Visit:_____

Reason:_____

Are You Satisfied with the Care Your Child has Received There: □ Yes □ No

Name of Pediatrician:_____ Date of Last Visit:_____

Reason:_____

Are You Satisfied with the Care Your Child has Received There: □ Yes □ No
# of Antibiotics Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____
# of Doses of Other Prescription Medications Your Child has taken: During the Past Six Months: _____
During His/Her Lifetime: _____ Please List:_____
Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife:_____
Complications During Pregnancy: □ Yes □ No List:_____
Ultrasounds During Pregnancy: □ Yes □ No Number:_____

Medications During Pregnancy/Delivery: □ Yes □ No List:_____
Cigarette/Alcohol Use During Pregnancy: □ Yes □ No
Location of Birth: □ Hospital □ Birthing Center □ Home
Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section If C-Section: □ Emergency □ Planned

Complications During Delivery: □ Yes □ No List:_____

Genetic Disorders or Disabilities: □ Yes □ No List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____ _____

Feeding History:

Breast Fed: □ Yes □ No How Long? _____
Formula Fed: □ Yes □ No How Long?_____ What Type?_____
Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months
Food/Juice Allergies or Sensitivities: □ Yes □ No List:_____

Developmental History:

During the following developmental stages your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Sit Up:_____ Stand Alone:_____ Hold Head Up:_____ Walk Alone:_____

Cross Crawl:_____ Respond to Sound:_____ Respond to Visual Stimuli:_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.). Has your child had a head-first fall? □ Yes □ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? □ Yes □ No List:_____

Has Your Child Ever Been Involved in a Car Accident? □ Yes □ No List:_____

Has Your Child Been Seen on an Emergency Basis? □ Yes □ No List:_____

Other Traumas Not Described Above? □ Yes □ No List:_____

Prior Surgery: □ Yes □ No List:_____

Menarche : □ Yes □ No Age:_____

Childhood Diseases: Please mark all that apply.

☐ Chicken Pox Age:_____ ☐ Mumps Age:_____
☐ Rubella Age:_____ ☐ Whooping Cough Age:_____
☐ Rubeola Age:_____ ☐ Other(s) List:_____

Authorization for Care of Minor

I hereby authorize this office and its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian:_____ Date: _____

Signature of Parent/Guardian:_____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize: Dr. Sharon Lark and whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to consent to any x-ray examination and chiropractic diagnoses or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general special supervision of any licensed chiropractor, to my _____

(Name of child)

This _____ day of_____20_____

Dated at _____

(City) (State)

Signed_____

Relationship to child _____

Lark Chiropractic
Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one primary goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission os mental impulses, resulting in a lessening of the body's innate ability to express it's maximum potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non- chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area.

Regardless of what the disease is called , we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRIMARY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I _____have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Patient signature) (Date)

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become informed prior to beginning care.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and rarely, fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence *does not* establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

Patient Name or legal Guardian(printed)	Date
Patient or legal Guardian Signature	Relationship to patient
Witness Signature (office staff)	Date

Patient Health Information Consent 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 form 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 office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this 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. The patient understands and agrees to allow this chiropractic office to contact them via electronic means such as through phone, fax, email, etc.

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 may provide a written request to revoke consent at any time during care. This would not effect 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.

5. 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.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the healthcare provider has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date