Crystal Lake
FAMILY WELLNESS

PATIENT APPLICATION FORM:
CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

_____

Patient name

_____

Date Completed

Today's Date: _____

Patient Information

Name: _____ Preferred Name: _____ (Age) _____ Gender: M F

Home Address: _____ Birth Date: _____ /_____ /_____

City, State, Zip: _____

Name of Mother/Guardian: _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W

Home Address (if different): _____ Cell Phone: ( ) _____ -_____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W

Home Address (if different): _____ Cell Phone: ( ) _____ -_____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Who can we thank for referring you to our office? _____

Purpose for This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? Y / N If yes, when: _____ /_____ /_____

If your child's symptoms are the result of an auto accident, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms: _____

_____

When did these symptoms begin? _____/_____ /_____ Are they: ☐ Constant ☐ Intermittent ☐ Activity-related

Are they getting worse? Y / N Do they interfere with: ☐ School ☐ Sleep ☐ Hobbies/Play ☐ Daily Routine

Explain: _____

_____

What activities aggravate these symptoms? _____

Is there anything that relieves your symptoms? Y / N If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? Y / N

If yes, explain: _____

_____

Name:_____ Date:_____

Health Questions

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

Cervical Spine (Neck)

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Colic
____ Sore throats
____ Auto-Immune Diseases
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Ear Infections
____ Learning disabilities
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking
____ Flu/Stomach disorders
____ Hyperactivity/ADD

Explanation(s):_____

Thoracic Spine (upper back)

____ Heart Palpitations
____ Shingles
____ Upper Back Pain
____ Heart Murmurs
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Asthma/Wheezing
____ Tachycardia (fast heart beat)
____ Recurrent Lung Infections

Explanation(s):_____

Thoracic Spine (mid back)

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Liver problems
____ Tired/Irritable after eating or when not having eaten for a while
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Spleen problems
____ Diabetes
____ Hypoglycemia
____ Diabetes
____ Other (please explain)

Explanation(s): _____

LUMBAR Spine (LOW back)

____ Pain in hips/legs/feet
____ Numbness/tingling in your legs/feet
____ Frequent/difficulty urinating
____ Menstrual irregularities/cramping (females)
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Low back pain
____ Coldness in legs/feet
____ Constipation/Diarrhea

Explanation(s):_____

Name:_____ Date:_____

OTHER

Please list any health conditions not mentioned: _____

_____

Please list any medications): _____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

History OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident (***if you check this item, please ask the front desk person for the corresponding form***)
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s): _____

_____

Birth Experience:

How long was labor? _____

Describe any complications: _____

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Vacuum Extraction ☐ Forceps Assistance

Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).***

____ ADD	____ Allergies/Hay fever*	____ Anemia	____ Appendectomy
____ Arthritis	____ Asthma	____ Bed wetting	____ Blood sugar problems
____ Broken bones/fractures	____ Cancer	____ Cerebral Palsy	____ Chicken pox/shingles
____ Circulatory problems	____ Crohn's/Colitis	____ Depression	____ Diabetes
____ Ear Infections	____ Eczema	____ Eczema/Psoriasis	____ Epilepsy/seizures
____ Fetal drug exposure	____ Food allergies*	____ Gall bladder	____ Headaches
____ Heart disease	____ Heart murmur	____ Hepatitis	____ Hernia
____ High blood pressure	____ HIV	____ Infectious disease	____ Influenza
____ Kidney Disease	____ Liver disease	____ Lumbago	____ Lung disease
____ Measles	____ Metal implants	____ Migraine headaches	____ Mumps
____ Neurological problems	____ Osteoporosis	____ Paralysis	____ Pleurisy
____ Pneumonia/Bronchitis	____ Polio	____ Rash	____ Rheumatic fever
____ Scoliosis	____ Seizure disorder	____ Sickle cell anemia	____ Small Pox
____ Spinal Bifida	____ Stroke	____ Thyroid problems	____ Tonsillectomy
____ Tuberculosis	____ Varicose veins	____ Whooping cough	____ Other*

Explanation of (*) item(s): _____

_____

Name:_____ Date:_____

Crystal Lake Family Wellness Terms of Acceptance

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a person seeks Chiropractic care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method 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 infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non- chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Parent/Guardian's name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Parent/Guardian's Signature:_____ Date: _____

Consent to evaluate and adjust a minor child

I,_____ being the parent or legal guardian of_____,
(Parent/Guardian's name) (Child's name)
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Parent/Guardian's Signature:_____ Date:_____

HIPAA
Notices of Privacy Practices
Crystal Lake Family Wellness

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (815) 788-7504.

Complaints – Complaints about your privacy rights or how our office has handled your health information should be directed to our Compliance Officer by calling (815) 788-7504. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (815) 788-7504.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Patient Name Date

_____

Patient/Guardians Signature