



PERSONAL INFORMATION

Please answer ALL the questions in detail to the best of your ability. (All information you give is confidential)

Today's Date: _____

Child's Name: _____ Female Male

Address: _____ City: _____ State: _____ Zip: _____

Home No. (_____) _____ Cell No. (_____) _____ Work No. (_____) _____

Date of Birth: ____/____/____ Age: _____ Height: ____ft ____in Weight: _____

Parent's Father's Name _____ Parent's Mother's Name _____

Whom may we thank for referring you? Dex Yellow Pages Yellow Book Online Insurance Walk-by Whole Foods Screening Talk by Dr. Borst Friend (please give name so we can thank them with a gift!) _____ Other _____

IN CASE IF EMERGENCY, CONTACT

Name _____ Relationship _____

Home No. (_____) _____ Cell No. (_____) _____ Work No. (_____) _____

REASON FOR THIS VISIT

Describe the purpose of this visit: _____

Is the purpose of this visit related to Sports Auto Injury Fall Home Injury Chronic Discomfort Other _____

Explain: _____ Has this condition Gotten Worse Stayed Constant Comes and Goes

Does this condition interfere with Sleep Daily Routine Other Activities Explain: _____

When did this condition begin? _____ Has this condition occurred before? Explain _____

Have you seen other doctor's for this condition? Yes No Dr's Name _____ Results _____

CHILD'S CURRENT AND PAST HEALTH CONDITION

Has your child been checked by a Doctor of Chiropractic? Yes No Who? _____

Were x-rays taken? Yes No Who is your regular pediatrician? _____

According to the National Safety Council approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually.

Can you recall any such jolts, falls or traumas to your child? Yes No Describe: _____

Any fractures or dislocations? Yes No Describe: _____

Other than school, does your child spend a lengthy time sitting? Yes No Is it in front of a computer or TV? Yes No

How would you rate your child's diet? _____ Does your child consume artificial sweeteners? Yes No

Check any of the following conditions your child has suffered from :

- Colic Allergies Bed Wetting Emotional Disorders
Irregular Sleeping Patterns Asthma Scoliosis ADD or ADHD
Night Terrors, Seizures Headaches Car Accident Other
Tantrums Poor Digestion Growing, Back or Neck Pains
Ear Infections Repeated Infections or Colds Learning Disorders

How often has your child been treated with drugs ? _____

How many prescriptions of antibiotics has your child taken in the last 6 months? _____ lifetime? _____

Is your child currently on any medications? Yes No (please list) _____

Any surgeries? Yes No (please list) _____

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

VACCINATIONS

The child's immune system is both complex and fragile. As with any medical procedure, there are risks associated with vaccinations. In fact, every year, health statistics show 12,000 to 14,000 hospitalizations, injuries, and deaths following vaccination are reported to the Vaccine Adverse Events Reporting System.

Has your child been vaccinated? Yes No If "Yes", check all vaccinations the child has received.

DPT MMR Polio Chicken Pox Hepatitis Other _____

Describe any and all reactions to vaccine(s): _____

Were you adequately informed of the risks of vaccinating your child? Yes No

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Please check the type of care desired so we may be guided by your wishes whenever possible.

- Relief Care** – Symptomatic relief of pain or discomfort
 Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms
 Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.
 Doctor's choice - I want the Doctor to select the type of care appropriate for my child.

Parents/Guardian's Signature _____ Date _____

BILLING

Who is responsible for this account? YOU and... Cash Auto Injury Personal Health Insurance Parent

If someone else other than patient please fill out the following:

Name: _____ Female Male Social Security No. _____ / _____ / _____

Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home No. (____) _____ Cell No. (____) _____ Work No. (____) _____

Is Child covered by additional insurance? Yes No

PAYMENT IS EXPECTED AT TIME OF VISIT

AUTHORIZATION TO CARE FOR MY CHILD

I hereby authorize the Doctors in this office, and whomever they may designate as their assistants to administer chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures to the spine, as the Doctor deems appropriate. I also certify that no guarantees or assurances have been made to me or my child as to the results that may be obtained.

I certify that if I, and/or my dependent(s), have insurance coverage I assign directly to Dr. Mitchell Borst and , all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions. Dr. Mitch Borst and may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services. I also authorize Dr. Mitchell Borst and to give chiropractic in an "open-door", adjusting environment, and can use my child's name on welcome boards, referral boards, sign-in sheets, and travel file use. I understand it is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An open-door approach involves the doctor moving from patient-care area to patient-care area. As a result, patients and patient files with patient names are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examination of present reports and findings. These procedures are completed in a private, confidential setting.

I also understand that if my child's care is suspend or terminated, any fee for professional services rendered to me will be immediately due and payable to Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic. If my account goes to collections I am responsible for any and all collection fees. I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient's Signature: _____ Date: _____

Guardian or Parent's Signature: _____ Date: _____