Anik J. St. Martin, DC, D.A.C.C.P.
Darin J. Shook, DC
Craig Werner, DC
John Dobosz, DC

Advantage
CHIROPRACTIC & MASSAGE

1312 Vandercook Way • Longview, WA 98632 • 360.425.6620 • Fax 360.425.1277
www.MyAdvantageChiro.com • contact@myadvantagechiro.com

Amy LaRiviere, LMP
Diane Miollis, LMP
Kim Clark, LMP
Matt Grimm. LMP

CHILDREN'S INTAKE FORM

Child's Name: ______________________ Birth Date: ____________ Age: _____ Sex: ☐ M ☐ F

Address: ______________________ City: ______________ State ______ Zip _______

Lives with ☐ Both Parents ☐ Mother ☐ Father_______ Referral/How did you hear about us?_______________

Names and Ages of Siblings: ________________________________

Mother's Name: ______________________ Email Address: ______________________

Address: ______________________ City: ______________ State ______ Zip _______

Home Phone: ______________________ Cell Phone: ______________________

Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________ Business Address: ______________________

Father's Name: ______________________ Email Address: ______________________

Address: ______________________ City: ______________ State ______ Zip _______

Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________ Business Address: ______________________

Person to Call if Unable to Reach You: ______________________

Phone # ______________________ Relationship: ______________________

Address: ______________________ City: ______________ State ______ Zip _______

Authorized Person to Discuss any Account Information: ______________________

Phone # ______________________ Relationship: ______________________

Address: ______________________ City: ______________ State ______ Zip _______

☐ I do not have personal health insurance.

In the absence of insurance, any non-covered charges become patient responsibility.

Newborns: Remember to call and update your insurance company to add your newborn to your policy.

Health Insurance Company ______________________

Billing Address ______________________

Phone ______________________ ID # ______________________ Group ______________________

Policy Holder's Name: ______________________ DOB:______________________

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Child History Form

Child's Name__________________________________ DOB______________

Has your child previously received Chiropractic care? ☐ Yes ☐ No Where?: ______________________________

Were X-rays taken? ☐ Yes ☐ No Who is your regular pediatrician? ______________________________

Height ______________________________ Weight______________________________

Purpose of This Appointment: ______________________ Has This Condition Occurred Before? ☐ Yes ☐ No

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? ______________________________

Type of Treatment: ______________________________ Medications: ______________________________

Results: ______________________________ When Did This Condition Begin? ____________________

How does it affect their body function and daily activities?______________________________

Experts around the world agree: the birth process as we know it may cause extensive neurological trauma and damage to the infant.

Did you have ultrasound during this pregnancy? ☐ Yes ☐ No Frequency? ______________________________

Provider: Midwife / OB-GYN / Other ________________________ Duration of Gestation: _________ weeks
Place of birth: Home / Birthing Center / Hospital Duration of Birth ______________________________
Type of Birth: Vaginal / C-section. Was anesthesia used? _______ Type ______________________________

Was labor induced? ☐ Yes ☐ No If yes, why? ______________________________

Was medication given to the mother at birth? (Including vaccines) ☐ Yes ☐ No If yes, what?____________________
What position did you deliver in: Squatting / On Back / Water birth
Birth trauma: Doctor Assisted / Twisting, Pulling / Vacuum Extraction / Forceps
Newborn trauma (medical procedures and tests) ______________________________

Was the delivery normal? ☐ Yes ☐ No If no, what complications were there at birth?____________________

APGAR at birth __________ APGAR after 5 minutes __________ Birth Weight __________ Birth Length __________

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? ☐ Yes ☐ No

If no, explain: ______________________________
At what age did the child: Respond to sound? ____ Follow an object? ____ Hold up head? ____ Vocalize? ____
Sit alone? ____ Teethe? ____ Crawl? ____ Walk? ____ Do his/her sleeping patterns seem normal? ☐ Yes ☐ No
Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes, etc.)

____
The father's side? ______________________________

Do the child's siblings have any health problems? ☐ Yes ☐ No If yes, describe: ______________________________

Psychological Stressors

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Any difficulties with lactation? ☐ Yes ☐ No Any problem bonding? ☐ Yes ☐ No

Does your child seem normal to you? ☐ Yes ☐ No Does your child have any behavior problems? ☐ Yes ☐ No

If yes, what? ______________________________

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? ☐ Yes ☐ No

If yes, specify: ______________________________ Average # of hours of TV/Computer per week? ____ hours

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Child's Name________________________________ DOB_____________

Chemical Stressors

During pregnancy, did the mother: Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No

Take supplements/vitamins? ☐ Yes ☐ No Take drugs? ☐ Yes ☐ No If yes, what? ____________________

Become ill? If so, how? ____

Receive invasive procedure (i.e. Amniocentesis, CVS)? ☐ Yes ☐ No If yes, please explain: ______________________

Was your child breast fed? ☐ Yes ☐ No If yes, how long? ____ weeks/months/years

At what age was formula introduced? ______ Brand?_____ Cow's milk? ______ years Solid Foods? _______ years

Did your child receive vaccinations? ☐ Yes ☐ No If yes, which ones?______________________________________

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term adverse effects from interfering with this process with artificial vaccines are just being uncovered.

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

Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? ☐ Yes ☐ No

Describe ____Was it reported by you or your doctor? ☐ Yes ☐ No

Has your child had antibiotics ☐ Yes ☐ No Was your child cultured for its use? ☐ Yes ☐ No

If yes, how many courses of antibiotics has the child had so far & why? ______________________________________
How often has your child been treated with other drugs? ____

Were you informed of their adverse reactions? ☐ Yes ☐ No

Is your child currently on any medications? (please list) ____
Any surgeries? ____

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No If yes, how many? ______

How would you describe your child's diet? ____

Does your child consume artificial sweeteners? ☐ Yes ☐ No Fluoridated water? ☐ Yes ☐ No

Traumatic Stressors

According to the National Safety Council approximately 50% of infants have fallen onto their heads during the first years of life. Another study reveals ¼ million children are injured on playgrounds annually.

Any evidence of trauma during birth? ☐ Bruises ☐ Odd shaped head ☐ Stuck in birth canal
☐ Fast and/or excessively long birth ☐ Respiratory Depression ☐ Cord around neck ☐ Other __________________

Any falls/accidents during pregnancy? ☐ Yes ☐ No Has the child had any major falls since birth? ☐ Yes ☐ No

If yes, did the child need stitches or cause a fracture or dislocation? Describe: ________________________________

Any hospitalizations? ☐ Yes ☐ No Explain: ____

Does your child play sports? ☐ Yes ☐ No # of hours per week? ______ Age child began ______ years

Which ones? Soccer / Football / Gymnastics / Karate / Hockey / Lacrosse / Basketball / Dance / Wrestling / Baseball
Other ____
Weight of school backpack? _______ lbs. Approx. hours spent at play per weeks? _______ hours

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

CONDITIONS Check (✓) conditions your child currently has or had in the past.			
☐ Colic	☐ Chicken Pox	☐ Tantrums	☐ Ear Infections
☐ Irregular Sleeping Patterns	☐ Diabetes	☐ Headaches	☐ Allergies
☐ Night Terrors	☐ Bronchitis	☐ Asthma	☐ Bed Wetting
☐ Seizures	☐ Suicide Attempt	☐ Poor Digestion	☐ Repeated Infections / Colds
☐ Emotional Disorders	☐ ADD or ADHD	☐ Learning Disorders	☐ Joint pain. Where?
☐ Neck pain	☐ Mid back pain	☐ Low back pain	☐ Coordination problems
☐ Other			

AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS

I, ________________________________ (Parent or Legal Guardian) authorize Advantage Chiropractic Staff to take and publish photographs of my child, _________________________(child name), for clinical records. Such photographs may be used in publications for the purpose of scientific and/or clinical research, chiropractic education, and the promotion of chiropractic health care, when deemed such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization.

Signature of Responsible Party: ____ Date: ______________________

OFFICE POLICIES

Please be on time for your appointment. Being late or last minute cancellations cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.

Please DO NOT wear strong perfumes or colognes. We see many patients with allergies and respiratory problems, strong scents can impair their progress.

Continued cancellations or missed appointments may result in being released from care.

Please notify the Doctor of **any changes in your health status**, regardless of the significance.

Children are welcome here as patients and guests. If you bring children with you for your appointment, you are responsible for their actions at all times.

For your children's safety they may not play with the exercise equipment, adjusting tables or window blinds.

Food is not allowed in the office due to food allergies of other patients, especially children.

Please silence cell phones or leave them in your car.

Signature of Responsible Party: ____ Date: _____________________

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is very 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

The tense muscles and ligaments in the pelvis, caused by misalignment in the sacrum may lead to constraint in the uterus. When the uterus is torqued and constrained in this manner, it is more difficult for the baby to move into the best possible position for birth. Webster Technique is a specific chiropractic adjustment which corrects subluxations of the sacrum. As a result, the mother’s tense pelvic muscles and ligaments relax, enhancing the physiological environment needed for normal baby position.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. We do not offer to diagnose or treat any condition. We are not turning malpositioned babies. We do not determine baby position. This technique is a specific chiropractic adjustment which removes interference to the nervous system, balances pelvic muscles and ligaments, alleviates constraint to the mother’s uterus allowing for optimal baby positioning. Our care is detection of and specific adjusting of vertebral subluxations.

All questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I have read and was supplied a copy of the **HIPPA guidelines.**

Consent to Evaluate and Adjust a Minor Child

I, ________________________________ being a parent or legal guardian of ____________________________ have read and
(Parent or Legal Guardian) (Child)

fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature of Responsible Party: ____ Date: ______________________

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FINANCIAL POLICIES

Payment is expected at the time of service.

We accept the following forms of payment; Cash, Personal Checks, Debit Cards, Visa and MasterCard.

No balance policy: Any patient responsibility is expected at the time of service. Balances after insurance payments and any non-covered charges by insurance are due upon receipt of your statement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Late Fee: A late fee of $10.00 will be imposed on each account that is over thirty (30) days past-due. All balances will accrue a $10.00 late charge every billing cycle.

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Massage no show/late cancellation fee: If you do not show up for an appointment, or cancel with less than 24 hours' notice, a $10.00 fee will be charged. This late no show /cancellation fee goes directly to our massage therapists for compensation of time loss.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. All delinquent accounts bear interest at the legal rate. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance Billing: If we are contracted with your insurance company, we must follow our contract and their requirements. **Copays are due at the time of service.** It is the insurance company that makes the final determination of your eligibility.
We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
If you have any visit limit or dollar maximum it is your responsibility to keep track of this and be aware of your benefits.
Insurance coverage is never a guarantee of payment. If there are any problems between the insurance company and the patient, the patient would need to file a grievance directly with the insurance company. Your signature below indicates assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

Your insurance company determines benefits when they receive our claims. Any statement made by our staff regarding your coverage is in no way a guarantee of payment for your services. I acknowledge that I am responsible for payment of all non-covered services.

Non-Contracted Insurance Billing: If you see a non-contracted (out of network) provider your insurance company may send you a check. You will need to sign the check and return it to our office for services rendered. I acknowledge that I am responsible for payment of all non-covered services.

Medicare: Medicare does not cover the following services at a Chiropractic office: Massage, Exams, Re-exams, X-Rays, Therapeutic exercises, Durable medical equipment or Supplements. We expect payment for any non-covered Medicare service at the time of your visit. If you have a copay with your supplemental insurance, it is to be paid at the time of your visit.

Workers Compensation: We require approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.
In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company. In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied or you exceed your benefits. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

By signing below, I acknowledge that I understand the policies contained herein.

Print Patient's Name: ______________________________

Print Responsible Party's Name (if not the patient): ______________________________

Signature of Responsible Party: ______________________________ Date _____/_____/_____