



AWAKEN TO WELLNESS PRE-SCHOOL PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION:

Child's Name: _____ Child's Nickname: _____

Sex: M / F Date of Birth: _____ Age: _____ Home Phone: (____) _____

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

How did you hear about our office? _____

Current Height: _____ Current Weight: _____

Purpose of this appointment: _____

FAMILY INFORMATION:

Father's Name: _____ Mother's Name: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Father's Work # _____ Mother's Work # : _____

Parent's Marital Status: Single Married Divorced Widowed

Email: _____

List Ages of Other Children in Family: _____

OFFICE POLICY:

Welcome to our office! Our goal is to serve your family with exceptionally friendly and prompt service, and provide the best family health care available.

The office is a place of healing. In consideration of other patients all cell phones must be turned off during your time in our office.

APPOINTMENT SCHEDULING:

Doctors and wellness coaches will design a specific course of action to allow proper care for your child. It is important for your child's health to keep all scheduled appointments. If an appointment must be changed, 24 hours notice is requested. All missed appointments should be made up within 7 days. Occasionally the office is closed while the staff is attending seminars. We will build your child's schedule around those times.

NOTICE OF PRIVACY PRACTICES / STANDARD AUTHORIZATION OF USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby voluntarily authorize Awaken to Wellness/Carpenter Chiropractic Center to release any and all medical information, until this authorization is further revoked, to:

_____ Relationship: _____

_____ Relationship: _____

_____ Pediatrician/ Family MD

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

The below named patient representative acknowledges they have received a copy of Notice of Privacy Practices.

Signature of Patient Representative: _____ Relationship: _____

Date: _____



FAMILY & FRIENDS:

Once you understand that the nervous system controls and coordinates all functions of the body and Subluxation interferes with nerve flow, we expect that you will want everyone you know checked. We offer a cost effective family program. We extend an opportunity for you to have your family and friends' health and wellness examined.

Insurance Information:

Awaken to Wellness/Carpenter Chiropractic Center is dedicated to our members and committed to providing the highest quality wellness care. Awaken to Wellness is an excellent investment in an individual's well being. We believe financial considerations should not be an obstacle to obtaining the care and coaching you desire.

In today's healthcare system, insurance participation can be confusing. It will be our pleasure to verify your chiropractic benefits for you. Most insurance companies provide some coverage for the services we offer in this office. Coverage varies and you may have limitations on the number of paid visits, deductibles or exclusions and may or may not have coverage. Awaken to Wellness/ Carpenter Chiropractic Center is not a participating provider with any insurance company including PPO's, HMO's, or Medicare. This office does not promise that insurance company will reimburse you for the usual and customary charges submitted by this office.

You are considered a cash practice member until our office "qualifies" your coverage to determine the extent of benefits under your policy. Members and their guardians are responsible for the payment in full of all fees for service. Unless other arrangements are made, payment is expected at the time of service regardless of insurance coverage.

At Awaken to Wellness/ Carpenter Chiropractic Center, we never want a financial challenge to get in the way of a family receiving care in our office. Therefore, we have established a fee schedule that creates affordable options for members. We are ready, willing, and able to assist you!

Printed Name: _____ **Date** _____

Signature: _____

AUTHORIZATION TO TREAT A MINOR:

I hereby request and authorize the doctors at Awaken to Wellness/Carpenter Chiropractic Center to perform any necessary diagnostic tests and render chiropractic adjustments and other needed treatments. As of this date, I have the legal right to select and authorize health care services for the minor child named above. *(If applicable)* Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Printed Name: _____ **Date** _____

Signature: _____



PREGNANCY HISTORY

What was the term of your pregnancy? _____ weeks

Total maternal weight gain: _____ lbs.

Maternal Nutrition and Exercise:

Any problems during pregnancy?

CHECK WHICH OF THE FOLLOWING YOU EXPERIENCED DURING PREGNANCY and EXPLAIN:

- Abnormal Bleeding _____
- Motor Vehicle Accidents _____
- High Blood Pressure _____
- Diabetes _____
- Anemia _____
- Falls _____
- Swollen Ankles _____
- Morning Sickness _____
- Indigestion _____
- Thyroid Problems _____
- Seizures _____
- Heart Problems _____
- Back Pain _____
- Hospitalizations _____
- Other _____

SOCIAL HISTORY WHILE PREGNANT: (circle all that apply)

Do you: 1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest

Do you smoke- (packs/day): 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do you Drink Coffee/Tea- (cups/day): 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do you Drink Alcohol- (drinks/day) : 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

MEDICATIONS WHILE PREGNANT:

List all including home remedies, prescription meds, non-prescribed drugs, and over-the-counter meds.

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |



LABOR AND DELIVERY HISTORY

Were there any problems during labor and delivery?

Third Trimester Presentation (circle): Vertex Breech Transverse Face/Brow

What was the location of the birth? (circle) Home Birthing Center Hospital

Type of Birth (circle): Normal Vaginal Forceps Planned Cesarean Suction/Vacuum Emergency Cesarean

Any Obstetrical Interventions?

BABY'S CONDITION AT BIRTH:

APGAR Scores: _____

Was there presence of any of the following? (check which apply)

- Jaundice (Yellow)
- Cyanosis (Blue)
- Congenital Anomalies

How was the baby's crying at birth? (check which apply)

- Cried immediately after birth
- Did not cry for _____ minutes
- Cried strongly
- Weak cry

Birth Weight _____ lbs Birth Length _____ ins

Was intensive care required? _____

Were there any medications given to baby at birth? _____

Were there any vaccines given to baby at birth? _____



PRE-SCHOOL CASE HISTORY

Pediatrician/Family MD: _____

Date of Last Visit: _____ Purpose: _____

Has your child ever seen a Chiropractor before? Yes / No When and by Whom? _____

Immunization History: _____

Number of Doses of Antibiotics Your Child has taken: During past 6 months _____ During Lifetime _____

Current Medications (What, How Much, & Why)? _____

Surgeries (what and when)? _____

Has Your Child Ever Sustained an Injury Playing Organized Sports? _____

Has Your Child Ever Been in an Automobile Accident? _____

At What Age, If Ever, Did Your Child Suffer From the Following?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____
Rubeola _____ Whooping Cough _____ Other _____

Has Your Child Ever Suffered From?

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Arm Problems |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Poor Digestion | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Other _____ | | |

Has Your Child Ever Suffered The Following Spinal Traumas?

- | | |
|---|---|
| <input type="checkbox"/> Fall in Baby Walker | <input type="checkbox"/> Fall from Bed or Couch |
| <input type="checkbox"/> Fall off Skateboard/Surfboard/Skates | <input type="checkbox"/> Fall from Crib |
| <input type="checkbox"/> Fall off Swing | <input type="checkbox"/> Fall off Bicycle |
| <input type="checkbox"/> Fall from Highchair | <input type="checkbox"/> Fall off Slide |
| <input type="checkbox"/> Fall down Stairs | <input type="checkbox"/> Fall from Changing Table |
| <input type="checkbox"/> Fall off Monkey Bars | <input type="checkbox"/> Other _____ |

Has your child ever had a bone fracture or joint dislocation? Yes / No Explain: _____

Does your child ever bang his/her head repeatedly against a wall, bed, or other object? _____

NUTRITION:

Do you have any concerns about your child's diet? _____

Does your child take vitamin supplements? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____