Lindenhurst Accident & Injury Center

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; preform 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

Patient Information

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

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

City, State, Zip: _____ Cell Phone: ( ) _____

Name of Mother/Guardian: _____ Home Phone: ( ) _____

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

Home Address (If different):_____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: _____ Home Phone: ( ) _____

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

Home Address (If different):_____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ☐Yes ☐ No If yes, when: ____/____/____

**If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding applications.*

Describe incident or reason for onset of symptoms: _____

_____

Please use the General Symptoms Chart on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin? ____/____/____ Are they: ☐ Constant ☐ Intermittent ☐ Activity-Related

Are they getting worse? ☐ Yes ☐ No Do they interfere with: ☐ School ☐ Sleep ☐ Hobbies/Play ☐ Daily Routine

Explain: _____

_____

What activates aggravate these symptoms? _____

Is there anything that relieves your symptoms? ☐ Yes ☐ No If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? ☐ Yes ☐ No

If yes, explain: _____

Have your child been treated for this? ☐ Yes ☐ No When was the last treatment? ____/____/____

Name of treating practioner/facility? _____

What treatment(s) was preformed? _____

_____

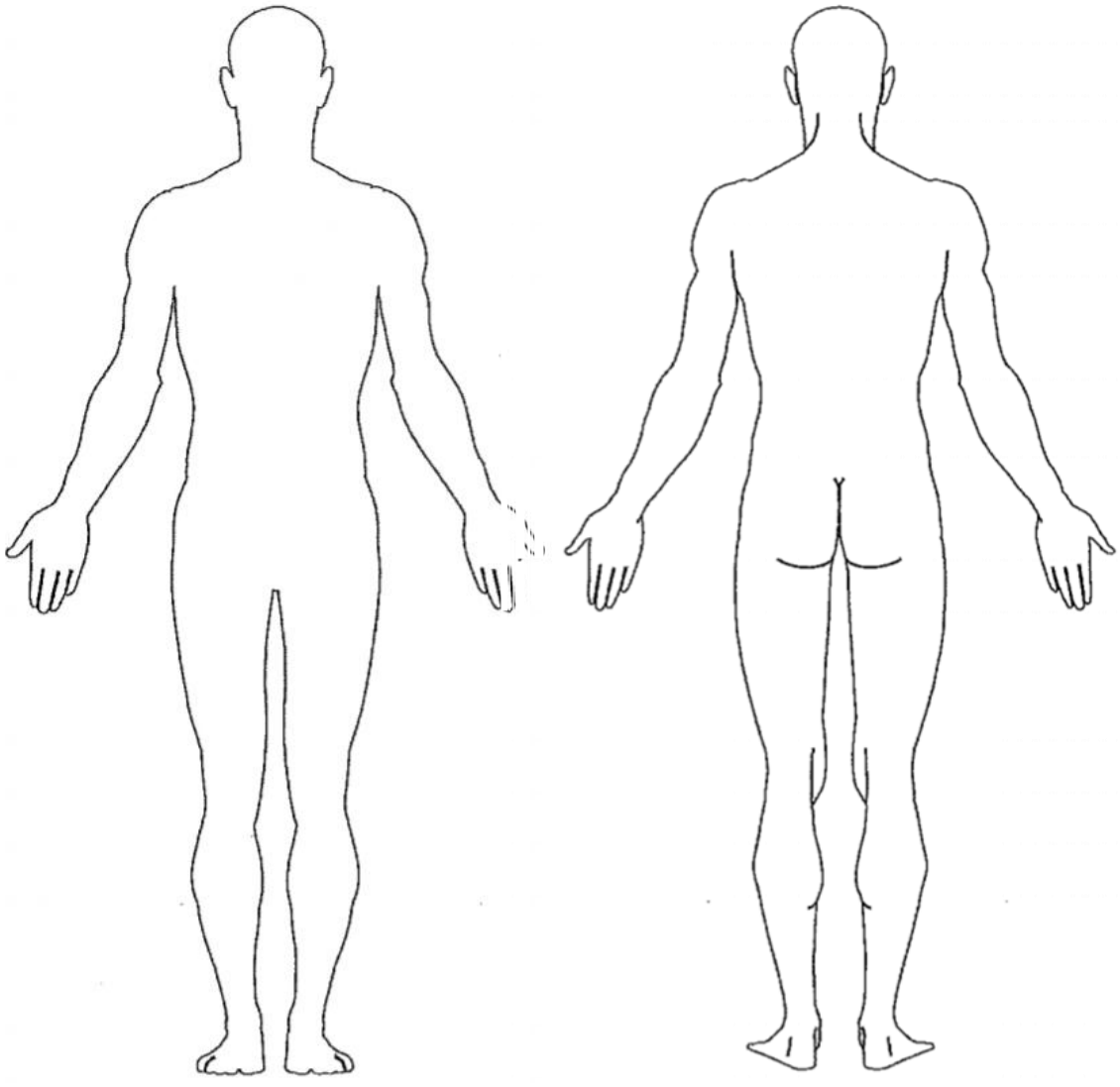
How did your child respond? _____

_____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it related to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT **BACK**

If you marked "O" for Other on any part, please explain below:

Health Conditions

Your spine is the foundation of health and core strength in you body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue I jury to the supportive structures of the spine, as well as shifts and distortions in while curves and sections 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)*
_____ Experiencing broken bones or rehabilitating 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

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: _____ ☐ Mos. ☐ Yrs. Where received: _____

2. _____ Age: _____ ☐ Mos. ☐ Yrs. Where received: _____

3. _____ Age: _____ ☐ Mos. ☐ Yrs. Where received: _____

4. _____ Age: _____ ☐ Mos. ☐ Yrs. Where received: _____

5. _____ Age: _____ ☐ Mos. ☐ Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site	____ Body rash or hives	____High fever (over 103 degrees)
____ High-pitched screaming	____Extreme sleepiness or unresponsiveness	____Body twitching or paralysis
____ Breathing problems (asthma, etc.)	____Excessive bleeding or anemia	____Head banging
____ Excessive diarrhea or chronic constipation	____Loss of memory/foggy state	____Muscle weakness
____ Chronic ear or respiratory infections	____Vision or hearing disturbances	____Joint pain
____ Crossing of eyes	____Seizures	____Other (please explain)

Explanation(s): _____

_____

_____

1. Postural and Degenerative Xyphosis: Freeman JT, Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846

Health Conditions *continued....*

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

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

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

Explanation(s):

_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

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

____ Heart Palpitations	____ Heart Murmurs	____ Asthma/Wheezing
____ Shingles	____ Shortness of Breath	____ Tachycardia (fast heart beat)
____ Upper Back Pain	____ Pain on Deep Inspiration/Expiration	____ Other (please explain)
____ Recurrent Lung Infections/Bronchitis/Pneumonia		

Explanation(s): _____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

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

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

Explanation(s): _____

_____

H**ealth Conditions *continued....***

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

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

____ Pain in hips/legs/feet ____ Weakness/Injuries in hips/knees/ankles ____ Low back pain

____ Numbness/tingling in legs/feet ____ Recurrent bladder infections ____ Coldness in legs/feet

____ Frequent/difficulty urinating ____ Muscle cramps in legs/feet ____ Constipation/Diarrhea

____ Menstrual irregularities/cramping (females) ____ Other (please explain)

Explanation(s): _____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

Please list any medications (Include name, dose, for what conditions, and how long your child has been taking it): _____

_____

_____

Please list any surgeries (Include type of surgery and date it was preformed): _____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following (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	____ Chron'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	____ Pollo	____ 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): _____

Experience With Chiropractic

Has your child seen a Chiropractor before? ☐ Yes ☐ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ☐ Yes ☐ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ☐ Yes ☐ No

Did they recommend a Home Health Care program? ☐ Yes ☐ No If yes, what? _____

How long was your child treated? _____ Last treatment: ____/____/____

How did your child respond?: _____

Are you aware of any poor posture habits in your child? ☐ Yes ☐ No

Is there any history of spinal problems in your family? ☐ Yes ☐ No

If yes, explain: _____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____

Patient's Signature _____ Date: ___/____/____

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnoses at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fee incurred will be due and payable at that time.

Patient's Signature _____ Date: ___/____/____

Patient's Name Printed _____

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed by the courts.

Guardian Signature _____ Date: ___/____/____

In Case of Emergency

Name _____ Relationship _____

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

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assigned or in any case where your benefit is processes directly to you regardless of assignment, you agree to submit any payment received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

DECLARATION

I clearly understand that all Insurance coverage, whether accident, work related, or general coverage is an arrangement between my Insurance carrier and myself, if this office chooses to bill any services to my Insurance carrier that they are preforming these services are strictly as a convivence to me. The doctor's office will provide any necessary reports or required information to aid in Insurance reimbursement of services, but I understand tat Insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my Insurance company does not cover, if this is the care are you willing to pay for these services? ☐ Yes ☐ No

Patient's Signature _____ Date: ___/____/____

Signature of Person Authorizing Care:

_____ Date: ___/____/____

Relationship to Insured: _____ Date of Birth: ___/____/____

Employer: _____

Primary Insurance Company: _____ Policy #: _____

Address Phone # ( ) _____

Insured's Name: _____ Insured's Social Security #: _____-____-_____

Secondary Insurance Company: _____ Policy #: _____

Address Phone # ( ) _____

Insured's Name: _____ Insured's Social Security #: _____-____-_____