Live Well
CHIROPRACTIC

age 0-6

Name _____ Age _____ DOB _____ Todays Date _____
Gender M F Parents Name _____ Parents Cell # _____
Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____
How did you find Live Well ___ online ___ location ___ referred by (name):_____

Main reason for consulting Live Well _____
Health condition #1 _____
When & how did the problem start _____ Severity 0 1 2 3 4 5 6 7 8 9 10
Any other details you would like us to know _____

Have you been to a chiropractor before? Y N _____

Mom use of fertility drugs/IVF:_____
Complications during pregnancy:_____
Ultrasounds during pregnancy: Yes No How many:_____
Medications during pregnancy:_____

In-utero constraint: ___ Breech Transverse Face/Brow presentation ___ None
Duration of gestation: _____ weeks Location of birth: ___ Home ___ Hospital ___ Birthing Center
Was the birth assisted: Y N if yes, how? Forceps Vacuum extraction C-section Induced
Vaginal ___ C-section_____ How long was labor:_____
Complications during delivery or shortly after?_____

Birth weight: _____ Length:_____ Any medication given to baby at birth?_____
Did baby spend any time in NICU after birth?_____

At what age did your child: Hold head up _____ Sit up alone _____ Teethe _____ Crawl _____
Walk _____ Eat Solid Foods _____ Sleep through the night _____
How long did your child crawl before they walked?_____
Normal crawl behavior or a modified crawl? (army crawl, shuffling on butt) _____

Breast fed or bottle fed?_____ How long?_____
Does child prefer one side to the other when feeding?_____
Does your child frequently spit up after feeding?_____
Does your child cry often?_____
Does your child pass a lot of intestinal gas?_____
Has your child shown any sensitivities to foods in your diet or their own?_____
Did your child receive vaccinations?_____ All recommended or modified schedule _____
Any reactions to any vaccinations? _____

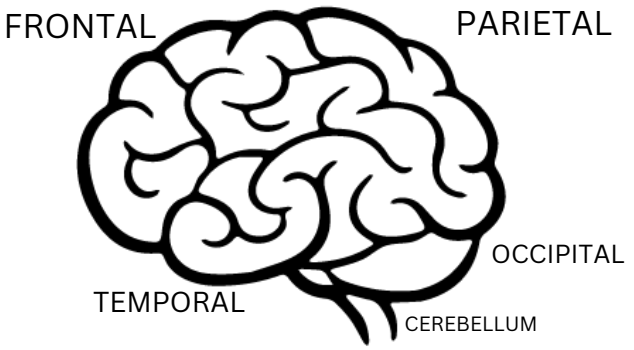
Has your child taken antibiotics?_____ How many times?_____
What is your child's diet like?_____
What supplements/vitamins do they take?_____
Does your child participate in any sports activities (or in the past)? _____
Have they been in any car accidents?_____ Other traumas/falls?_____

Brain based common complaints

please mark all that apply

Frontal Lobe

___ learning challenges
___ depression
___ mood swings
___ anxiety
___ concentration
___ speech difficulties
___ overall weakness
___ bed wetting/urgency
___ slow reaction time
___ slowness initiating movement



Live Well CHIROPRACTIC

Temporal Lobe

___ memory loss
___ hearing loss
___ tinnitus (ringing in the ear)
___ difficulty thinking of words
___ vertigo
___ tourette's
___ problems with taste/smell
___ difficulty with facial recognition
___ speech comprehension issues

Parietal Lobe

___ confusion betweem L & R
___ disorientation
___ navigation difficulties
___ clumsiness
___ missing spots while shaving
___ difficulty following stories
___ injuring one side more than the other

Occipital Lobe

___ visual floaters
___ color blindness
___ decreased brightness
___ visual auras

Cerebellum

___ tripping often
___ poor coordination
___ breathing problems
___ learning challenges
___ motion sickness
___ balance issues

Neurologic problems start at an early age.
Please check any of these that you can remember being present.

Rooting

___ speech issues
___ chewing/biting lips
___ involuntary tongue or mouth movements
___ oral sensitivities
___ difficulty with feeding

ATNR

___ poor handwriting
___ difficulty reading & tracking/ missing words when reading
___ poor hand-eye coordination

Babinski

___ delays in walking
___ balance issues
___ clumsy - tripping/falling
___ walking on tip toes

Palmer

___ poor find motor skills
___ poor/messy handwriting
___ poor pencil grip
___ poor eye/hand coordination

Spinal Galant

___ inability to sit still or remain silent
___ poor concentration
___ bed wetting
___ needing to have contact with someone while sleeping

Startle

___ sensitive to loud noise or light
___ mood swings
___ aggressive outbursts
___ feeling anxious
___ difficulty with change

Why are we asking about parts of your brain at a chiropractic office? Your brain & nervous system are the master coordinators of the function of the body. If there are imbalances in the brain it can lead to many health challenges.

CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize
(Name of Minor)

Live Well Chiropractic as agent(s) for the undersigned
(Name of Agent)

to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20_____,
(Date of child's 18th birthday) (Month and Day) (Year)

unless sooner revoked in writing delivered to the agent(s) noted above.

Date_____

Print Name: _____
(Parent/legal guardian/person having legal custody)

Relationship to Patient: _____

Signature_____
(Parent/legal guardian/person having legal custody)

Live Well Chiropractic

1330 SW 160th Ave
Sunrise, FL 33326
954-384-3275

NOTICE OF PRIVACY PRACTICES: The following are policies of Live Well Chiropractic and will be implemented unless patients notify Live Well Chiropractic in writing that they do not wish to participate:

OPEN ADJUSTING ENVIRONMENT:

It is the practice of Live Well Chiropractic to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being in the same adjusting area at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients and staff. The environment is used for ongoing care and is NOT the environment used for taking patient histories or performing examinations. These procedures are completed in a private, confidential setting. If there is ever a time that you would like to discuss something in private with one of the doctors just ask for a private setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related to an "open adjusting" environment are incidental matters. In the event, you or someone else would not agree with us, we are providing this disclosure.

• It is our desire for our staff to use your name, address, email address and/or telephone number for the purpose of contacting you to advise you about health-related meetings, workshops, and important office information such as office hour changes and cancellations.

• It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office visit.

• As a courtesy to our patients, if you miss an appointment, it is our policy to call your home to reschedule your appointment time. If you are not home, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality chiropractic care. If you choose to not authorize the use of this information, your decision will have no adverse effect on your care from Live Well Chiropractic or on your relationship with our staff.

Live Well Chiropractic reserves the right to change this notice and to make the revised Privacy Notice effective for all your protected health information that it contains.

Live Well Chiropractic Privacy Officer is Dr. John Moore. You may contact him at 954.384.3275.

ACKNOWLEDGMENT:
I acknowledge that I have been offered to review a copy of the Live Well Chiropractic Notice of Privacy Practices.

_____ _____ _____
Name of Individual (please print) Signature of Individual Date

If Patient is a Minor, _____ _____ _____
Signature of Individual Relationship Date

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Terms of Acceptance

Welcome to our office! We are excited that you have taken the first step to enjoying a healthier life through safe and effective chiropractic care. We hope to teach and inspire our patients to achieve higher standards of health and wellness. Before we begin there are a few things to review.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 eliminate major interference to the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

Signature Date