ABOUT THE PATIENT (Child)

Dr. Joshua A. Cebula, 340 E. Lakewood Blvd. Holland, MI 49424

Name _____ Today's Date:_____

Preferred Name (Nickname) _____ Birthdate _____

Address _____Cell Phone_____

City _____ State _____ Zip _____

Gender ❑ M ❑ F e-Mail Address _____

Have you been to a chiropractor before? ❑ No ❑ Yes Name of Medical Dr. _____

Emergency Contact _____ ph# _____

Who can we thank for referring you in today? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize All About You Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- *Person responsible for this account if other than the patient?*_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

5. What makes it better?_____

6. What makes it worse? _____

7. What Doctor's have you seen for this?_____

_____

8. Type of treatment:_____

9. Results: _____

ANTHING ELSE THE DR. SHOULD KNOW: _____

_____

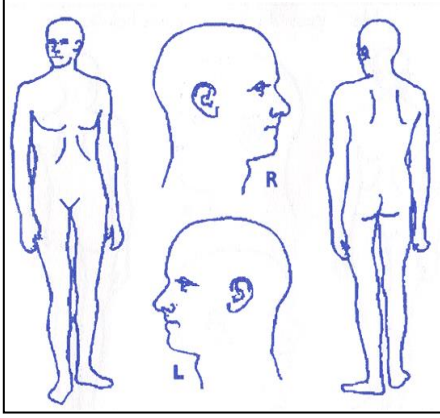
_____

_____

_____

_____

Please mark all areas of concern.



All About You CHIROPRACTIC
Dr. Joshua A. Cebula 340 E. Lakewood Blvd. Holland, MI 49424

GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. **List any medications being taken:** _____
2. **Number of courses of Antibiotics child has taken in the last 6 mo.**_____ **Total during lifetime**_____
3. **Name of Pediatrician and Other Doctors:** _____
4. **Date of Last Visit** _____/_____/_____ **Reason:** _____
5. **Name of Obstetrician/Midwife:** _____
6. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**
7. **Complications During Pregnancy:** ❑ **No** ❑ **Yes Explain:**_____
8. **Ultrasounds During Pregnancy:** ❑ **No** ❑ **Yes How Many:** _____
9. **Medication During Pregnancy / Delivery** ❑ **No** ❑ **Yes List:**_____
10. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**
11. **Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

12. **List any past auto collisions:**_____ **Was any care received?**_____
13. **List any past falls bumps bruises:** _____ **Was any care received?**_____
14. **List any past sport, recreational, or home injuries:**_____
15. **Please describe any past conditions and treatment received:** _____

_____

16. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____

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HIPPA PRIVACY PRACTICES

I acknowledge that All About You Chiropractic, LLC "Notice of Privacy Practices" has been made available to me. I understand I have the right to review All About You Chiropractic's Notice of Private Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at All About You Chiropractic, LLC.

The Notice of Privacy Practice is also posted on our website at www.aaycholland.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and All About You Chiropractic, LLC's duties with respect to my protected health information. All About You Chiropractic, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

_____

INFORMED CONSENT

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

Print Name: _____Signature:_____Date:_____

ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the All About You Chiropractic Clinic Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.aaycholland.com. It is also provided upon request at the main administration desk.

I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

My signature also authorizes the payment be made directly to All About You Chiropractic for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

I understand and agree that All About You Chiropractic has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of All About You Chiropractic to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Signature of Patient/Patient Representation Date