Dr. Dwight L. Agee
Dr. Lauren P. Cobb

CHIROPRACTIC AND WELLNESS CENTER, P.C.

Thank you for allowing us the opportunity to take care of your child. Please complete the following so we can better serve your child. It is our pleasure to welcome you to our chiropractic family.

Child's Name: ______________________________ DOB__________ SSN______________

Sex: ________ Height____________ Weight____________

Address: ____

City: ______________ State______ Zip__________

Father's Name: ____________________ Mother's Name___________________

Father's Cell Phone: _________________ Mother's cell Phone________________

Home Phone: ___________________ Email Address________________________

In Case of Emergency Please Contact_____________________________

Phone Number___________________ Relationship___________________

Responsible Party____________________ Relationship_____________________

DOB_________________ Responsible Party Signature_____________________________________

Whom may we thank for referring you to our office? ____________________________

Reason(s) for seeking care: Spinal check-up Wellness Other

Please explain: ___________________

Other Drs seen for this condition? Y / N If yes, Dr's name & prior treatment:_______________

____

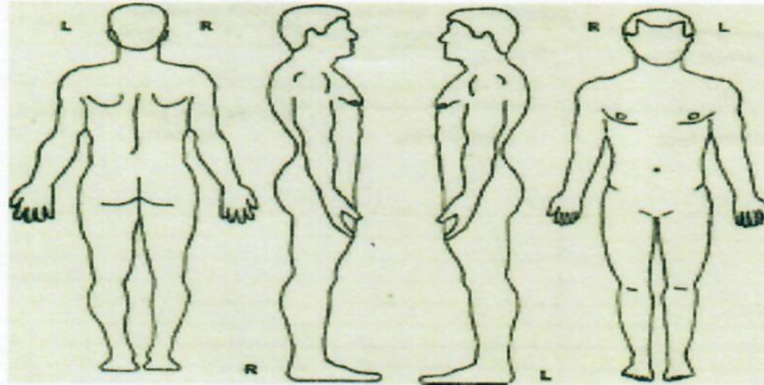
Previous chiropractor: ___________________ Date of last visit: __________

Reason: ____________________

Name of Pediatrician: ___________________ Date of last visit ___________

Reason: ____________________

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



Other Health Problems

Please circle any current or past problems your child has had:

Dizziness	Sinus Trouble	Nightmares	Growing Pains
ADHD	Diabetes	Anemia	Broken Bones
Autism	Tuberculosis	Rheumatic Fever	Sprains/Strains
Backaches	Hypertension	Poor Appetite	Fainting
Neck Pain	Arthritis	Hyperactivity	Hernias
Headaches	Heart Condition	Behavioral	Arm/Elbow Pain
Allergies	Rash/Hives	Poor Memory	Leg/Hip Pain
Asthma	Digestive	Insomnia	Knee/Foot Pain
Runny Nose	Neuritis	Bed Wetting	Joint Pain
Itchy Eyes	Cough/Wheeze	Pain urinating	Scoliosis
Ear Infections	Chest Pain	Convulsions	Blood Disorders
Frequent Colds	Constipation	Paralysis	Stomach Aches
Fever/Chills	Diarrhea	Muscle Pain	Other

Please list any medications your child is taking and conditions being treated: ____________________

____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking: ________________

____

Number of rounds of antibiotics your child has taken: _______________ Has your child been injured in any type of accident (IE sports, car accident, major fall, etc)? Y / N

If yes, please describe: ____

Prior Surgeries/Operations? ____

____

Prior Hospitalizations? ____

____

Family History

Family History	Living? Medical problems if any:	Deceased? Cause of death:	Age
Mother			
Father			
Brother			
Brother			
Sister			
Sister			

Vaccination History:

Up to date   Chose to decline vaccinations   Chose a delayed schedule   Still deciding

Please describe any adverse reactions to vaccinations: ______________________________

____

Prenatal History:

Name of Obstetrician/Midwife: ______________________

Location of birth:

Hospital: ________________ Home________________ Birth Center: ________________

Complications during pregnancy? Y / N

Describe____

Medications during pregnancy? Y / N

Describe____

Cigarette/Alcohol during pregnancy? Y / N

If yes, please list____

Ultrasound during pregnancy? Y / N

Chiropractic care during pregnancy? Y / N

Medications used during birth:

None Pitocin Epidural

Interventions used during birth:

Breaking of water Vacuum Forceps Episiotomy

Complications during birth? Y / N

If yes, please Describe____

____

Position of baby at birth

Head down Posterior/Sunny side up Breech Malposition

How long was your labor? ____________

Cesarean section? Y / N

If yes, was it: □ Planned □ Emergency

Genetic Disorder/Disability? Y / N

If yes, please describe

Birth Weight: ______________ Birth Length: ______________APGAR scores: ____________

Number of weeks of gestation at birth: __________

Feeding History:

Breastfed: Y/N How long? ______________________

Formula Fed Y/N How long? __________________Which Formula? ____________________

Does baby prefer feeding on one side more than the other? Y/N

Introduces to Solids at __________ months.

Introduced to cow's milk at___________ months

Food/Juice allergies, sensitivities, or intolerances? Y/N

If yes please list:____

Developmental History

Number of hours of sleep per night: ______________________________

Quality of sleep: ☐ Good ☐ Fair ☐ Poor

During the following times, your child's spine is most vulnerable to stress and should be routinely check by a Doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sounds________________ Hold head up____________________

Sit up______________________________ Crawl__________________________

Stand-alone________________________________ Walk alone______________________

Childhood Diseases

At what age (if ever) did your child suffer from the following:

Chicken pox______________________________Rubella_______________________________________

Measles____________________________________Mumps_______________________________________

Whooping cough___________________________Other____

<u>WE ARE HERE TO SERVE YOU AND YOUR FAMILY AND HIGHLY ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.</u>

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand that my child is being treated for spinal misalignments.

Parent or Guardian Signature: _______________________________________

Parent or Guardian Print Name: ______________________________________

Signature Date____

I, ____(Patients Name) hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to AGEE CHIROPRACTIC AND WELLNESS CENTER, P.C. (the "center") such sums as benefits, health and accident, benefits workman's compensation benefits, or any other insurance benefits obligated to reimburse me or form any settlement judgment or verdict on my behalf as may be necessary to adequately protect said center. I understand that I remain personally responsible for the total amounts due to the center for their services. I further understand and agree this assignment, lien and authorization does not construe any consideration for the center to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that I am financially responsible to the center for all charges not covered by my insurance company. I further agree that in the event of non-payment, I will bear the cost of collection fees (331/3% of balance), and/ or court cost and reasonable legal fees, should this be required. I authorize the center to release any information pertinent to my case to my insurance company, adjuster, or attorney or 3rd party-review board, employer- to facilitate collection under this Assignment, Lien and Authorization. I agree that the able mentioned center may be given power of attorney to endorse/sign my name on ant and all check for payment of services rendered. I hereby authorize the center (or whomever they may designate as assistants), to administer such treatment as is necessary, and to perform the appropriate therapy, manipulation, and additional diagnostic procedures as considered chiropractically necessary on the basis of findings. This serves as a long-term authorization that applies to all occasions of service until it is revoked.

______________________________ ____________________ __________________

Patient Signature Date Witness Signature

Listed below are the persons, including all of my medical doctors, who are involved in my care with whom you may share my protected health information regarding my treatment or payment issues:

Name/Relationship/Phone Number: ____

____

X______________________________________ ________________

Patient Signature (or Parent if Minor Child) Date

I ______________________________ (Name of Individual) consent to Agee Chiropractic Center's ("the Practice's") useand disclosure of myProtected Health Information forthe purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Healthcare operations purposes shall include, but notbelimited to, quality assessment activities, credentialing,business management and other general operation activities. I understand that the Practice's diagnosis or the treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future paymentfor the provision ofhealth careservices to me; and thateither identifies meor from which there isa reasonable basisto believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of t treatment, payment or healthcare operations of the Practices, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to restriction that I request, the restriction is binding on the Practice. I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my right and the Practice's duties regarding the types of uses and disclosures of my Protective Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has active in reliance on this consent.

X______________________________ ______________________

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________(Patients Name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Agee Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

______________________________ ______________________ ______________________________

Patient Signature Date Witness Signature