TEEN APPLICATION FOR CARE

Whom may we thank for referring you? ___________________________________

PATIENT INFORMATION (Please Print)

Child's Legal Name: ________________________________ ❑ Male ❑ Female Date of Birth: _______ / _______ / _________

Address: ________________________________ City/State: ______________________ Zip: ______________

Mom's Name ________________________________ Mom's Phone #: ________________________________

Mom's Email Address: ________________________________ Mom's Social Security #: ________________________________

Dad's Name ________________________________ Dad's Phone #: ________________________________

Dad's Email Address: ________________________________ Dad's Social Security #: ________________________________

Pediatrician: ________________________________ Pediatrician Phone #: ________________________________

❑ I authorize this clinic to leave voice messages on all answering devices and to send text messages to capable devices.

❑ I authorize this clinic to send me emails for reminders and informational newsletters.

❑ I authorize this clinic to leave or give information to a spouse, emergency contact or any members of the household.

Why have you decided to have your child evaluated by a Chiropractor?

❑ He/She is continuing ongoing care from another chiropractor.
❑ I want to improve my child's immune function.
❑ I have concerns about his/her health and I'm looking for answers.
❑ I recently had my spine checked and understand the value.
❑ He/She has a specific condition and I've learned that chiropractic may be able to help.

WELLNESS PROFILE

What signals has your child's body been communicating?

Current	Previous		Current	Previous		Current	Previous	
❑	❑	Asthma	❑	❑	Frequent Diarrhea	❑	❑	Low Back Pain
❑	❑	Digestive Problems	❑	❑	Constipation	❑	❑	Mid Back Pain
❑	❑	Sinus Problems	❑	❑	Ear Infections	❑	❑	Shoulder Pain
❑	❑	Weight Challenges	❑	❑	Heartburn	❑	❑	Hip Pain
❑	❑	Bed Wetting	❑	❑	Strep Throat	❑	❑	Knee / Foot Pain
❑	❑	Sleep Problems	❑	❑	Frequent Colds	❑	❑	Neck Pain
❑	❑	Seizures	❑	❑	Recurrent Fevers	❑	❑	Headaches/Migraines
❑	❑	Food Sensitivities	❑	❑	Eczema	❑	❑	TMJ
❑	❑	Tremors/Shaking	❑	❑	Rashes	❑	❑	Scoliosis
❑	❑	ADD/ADHD	❑	❑	Allergies	❑	❑	Autism/PDD
❑	❑	Other: ________________________________						

Does your child appear to be in pain or discomfort? _______ How long has your child been experiencing this? _________________

Is it getting better, worse or staying the same? _______ Was the onset sudden or gradual? _________________________

Has your child taken any medication for this complaint? ❑ No ❑ Yes ____

Physical Traumas

Complications during pregnancy? ❑ No ❑ Yes ____________________

Was your child born via c-section? ❑ No ❑ Yes ____________________

Were there any complications during delivery? ❑ No ❑ Yes ____________________

Has your child ever fallen from any high places? ❑ No ❑ Yes ____________________

Has your child ever been involved in a motor vehicle accident? ❑ No ❑ Yes ____________________

Has your child ever been seen on an emergency basis? ❑ No ❑ Yes ____________________

Has your child broken any bones? ❑ No ❑ Yes ____________________

Has your child had any previous hospitalizations? ❑ No ❑ Yes ____________________

Has your child had any previous surgeries? ❑ No ❑ Yes ____________________

Does your child spend time using a tablet, computer or phone? .... ❑ No ❑ Rarely ❑ Daily ❑ Several hrs/day

Does your child watch television? .... ❑ No ❑ Rarely ❑ Daily ❑ Several hrs/day

Does your child exercise? .... ❑ No ❑ Rarely ❑ Daily ❑ Several hrs/day

Does your child play contact sports? .... ❑ No ❑ Daily ❑ Weekly ❑ Seasonally

Does your child sleep on their .... ❑ Back ❑ Belly ❑ Sides

Does your child carry a backpack? ❑ No ❑ Yes

How many times per week does your child exercise? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7-9

Chemical Stressors

Does your child receive annual flu shots? ❑ No ❑ Yes (Informed decision) ❑ Yes (Recommended by MD)

Has your child been exposed to antibiotics? ❑ No ❑ Yes

If yes, how many doses in past 6 months? __________ Reason ____________________

How many glasses of water per day does your child have? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7-9 ❑ 10+

How many glasses of cow's milk, juice or soda per day does your child have? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7-9 ❑ 10+

Does your child eat gluten? ❑ No ❑ Yes ❑ Trying to eliminate from diet

Does your child eat dairy? ❑ No ❑ Yes ❑ Trying to eliminate from diet

Does your child eat refined sugars, white bread and pasta? ❑ No ❑ Yes ❑ Trying to eliminate from diet

Does your child eat boxed/frozen foods? ❑ No ❑ Yes ❑ Trying to eliminate from diet

Do you choose organic foods? ❑ No ❑ Yes If yes, which: ❑ Veggies ❑ Fruits ❑ Meats ❑ Grains ❑ All

Does your child eat any artificial sweeteners like Splenda, Aspartame or Diet Soda? ❑ No ❑ Yes

Any food allergies, sensitivities, intolerance? ❑ No ❑ Yes ____________________

Is your child exposed to second hand smoke? ❑ No ❑ Yes

Does your child take a probiotic daily? ❑ No ❑ Yes __________ CFU's/day

Does your child take vitamin D3 daily? ❑ No ❑ Yes __________ IU's/day

Other supplements ____________________

Is your child exposed to cleaning products or industrial chemicals? ❑ No ❑ Yes

Have you ever noticed mold growing in your home? ❑ No ❑ Yes

How often does your child take over the counter medications? ____________________

Patient's Name ____________________ **File #** ____________________

Consent

I understand that I am directly and fully responsible to Keen Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Printed Name of Patient ____

Patient or Authorized Person's Signature ______________________ **Date Completed** _____ - _____ - _____

Relationship to patient ____

Printed Name of Doctor of Chiropractic ____

Signature of Doctor of Chiropractic ______________________ **Date Reviewed** _____ - _____ - ______

Informed Consent Regarding X-rays/Imaging Studies

MALES ONLY

By my signature below I have conveyed my understanding of the risks associated with exposure to x-rays and after careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient / Authorized Person's Signature ______________________ **Date Completed** _____ - _____ - _____

Patient's Name ______________________ **File #** ______________________

Witness Signature ______________________ **Date Form Reviewed** _____ - _____ - _____

FEMALES ONLY

The first day of my last menstrual cycle was on ______-______-______ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient / Authorized Person's Signature ______________________ **Date Completed** _____ - _____ - _____

Patient's Name ______________________ **File #** ______________________

Witness Signature ______________________ **Date Form Reviewed** _____ - _____ - _____

Our Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Keen Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and Keen Family Chiropractic retains the signature sheet.

Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like another copy of this notice one will be provided to you. Once you have read this notice, please sign and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like a digital copy of them we would be happy to provide this on a cd for you at no cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Kelsie Keen at (512) 335-8700. If she/he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Note: Patient retains the above Notice of Privacy Practice and Keen Family Chiropractic retains the signature sheet.

Office Policies and Notice of Privacy Practice Signature Sheet

Patient retains the Office Policies and Notice of Privacy Practice and Keen Family Chiropractic retains this signature sheet.

OFFICE POLICIES

I hereby acknowledge receiving a copy of the practices 'Office Policies' document, which I have read and retained. This page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient or Authorized Person's Signature ____ **Date Completed** _____ - _____ - _____

Patient's Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____

NOTICE OF PRIVACY PRACTICE

I have received a copy of Keen Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient or Authorized Person's Signature ____ **Date Completed** _____ - _____ - _____

Patient's Name ____ **File #** ____

Witness Signature ____ **Date Form Reviewed** _____ - _____ - _____