NEUROEDGE CHIROPRACTIC

Name _____ Cell Phone _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth ____/____/____ Male/Female Age _____

Email _____

Name of Parents _____

The majority of children have experienced hundreds of impacts that could cause vertebrae to become misaligned or subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? Easy/Stressful/Complicated/Surgical

How long was the entire labor? _____
How long did you push for? _____
Were you induced? ☐Yes ☐No
Nerve Block ☐Yes ☐No
C-Section? ☐Yes ☐No
Was there any pulling on the head? ☐Yes ☐No
☐Midwife ☐OBGYN ☐Forceps or vacuum extraction

Science has shown that 47% of all children fall on their heads by the age of one and have at least 200 major falls by the age of 5 years old.

When was your child's most recent fall? _____
Was any care given? ☐Yes ☐No Was he/she checked by a chiropractor for subluxation? ☐Yes ☐No

And the fall before that? _____
Was any care given? ☐Yes ☐No Was he/she checked by a chiropractor for subluxation? ☐Yes ☐No

What sports or recreational activities does your child do? _____

When was your child's most recent stress, strain or injury while doing these activities? _____

_____

Was any care given? ☐Yes ☐No Was he/she checked by a chiropractor for subluxation? ☐Yes ☐No

Has your child ever been involved in a motor vehicle accident as a passenger? ☐Yes ☐No
Briefly describe: When/Details? _____

_____

Child Seat? ☐Yes ☐No
Seat Belt? ☐Yes ☐No
Front Seat OR Back Seat? _____
Was any care given? ☐Yes ☐No
Was he/she checked by a chiropractor for subluxation? ☐Yes ☐No

This information is important. Thank you for explaining your child's history of accidents and traumas. This will help the doctor better understand where the spine Is damaged or subluxated. What we need to do now is ask you a few questions regarding your child's current health concerns.

Does your child have any health concerns? ☐Yes ☐No
What are they? _____
If so, how long have they been present for? _____

Subluxated vertebra will cause irritation to nerve fibers affecting organs and tissue leading to sicknesses and illness.

Are there any other conditions your child is or was experiencing? ☐Yes ☐No
How long and details? _____

Depending on where and the degree of the subluxated vertebra, nerve pressure can be constant or occasional.
How often does your child have this condition(s)? _____
Does your child take multi-vitamins regularly? ☐Yes ☐No
What other supplements does your child take? _____
Please list all medications your child takes: _____

_____

Signature of Parent OR Guardian: _____ Date: _____

Authorization For Care

I hereby authorize the Doctor to work with my condition through the use of the adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills insured at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignments of my insurance rights and benefits (if applicable) directly to provider of services rendered.

X _____ X _____

Patient Signature Guardian Signature

Who should receive bills for payment on your account?

☐Patient ☐Spouse ☐Parent ☐Work Comp ☐Medicare ☐Personal Health Insurance ☐Auto Insurance

Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____
ID # _____
Group # _____
Address _____
Phone Number _____

Office Policies & Procedures

please initial highlighted

_____1. **Symptoms:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

_____2. **Appointments**: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness and avoid being charged a $20 fee. It is your responsibility to get here. We will do all we can to accommodate you.

_____3. **Dynamic Examinations**: During your Initial Intensive Care you will receive several Dynamic Examinations to monitor your level of spinal correction. On this visit, you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending approximately 30 extra minutes on these days. Immediately following your Dynamic Examination, the doctor will sit down with you to discuss your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

_____4. **Exercise:** Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, disks, and nerves. However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced. We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

_____5. **Nutrition**: Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs on a daily basis.

_____6. **Results:** We are very results oriented, however many factors that we have no control over affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

PATIENT: _____ DATE: _____

WITNESS: _____

Congratulations on choosing Chiropractic. Follow through with your family, and enjoy the health benefits that come with a Chiropractic lifestyle.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Neuroedge Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Neuroedge Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient or Guardian's Signature

Marty Carlson D.C.
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Murrieta, Ca. 92562
951-304-2242
mcarlsondc@yahoo.com
www.neuroedgechiropractic.com

Print Full Name: _____

Credit Card Authorization

I, _____, give authorization to Neuroedge Chiropractic to charge my card in the amount of $20 for any missed appointments or canceled appointments without a 24 hour notice. I acknowledge that I am legally responsible for any and all charges and I authorize my card to be charged the total of any back balance if I decide to discontinue my care.

( ) Visa ( ) Master Card

Card Number: _____
Expiration Date: _____
Security Code (3 digits): _____

Signature: _____ Date: _____