The Healing Room
CHIROPRACTIC, LLC

CONFIDENTIAL PATIENT INFORMATION

Date_____/_____/_____ Patient Number_____

Last Name_____ First Name_____ MI____ Gender: ☐ Male ☐ Female

Address: _____

Home Phone_____ Date of Birth_____/_____/_____ Age_____

Parent or Guardian Full Name: _____ Parent SS# _____

Address (if different from Child)_____

List your major health complaints & areas of pain_____

Breast fed: ☐ Yes ☐ No How long:_____ Full term? _____

What type of birth: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Suction Cup Location? _____

Presentation: ☐ Normal ☐ Breach ☐ Frontal With anesthesia (pain killer): ☐ Yes ☐ No

Type used: ☐ Oral ☐ Hypo ☐ Epidural ☐ Subdural Injection ☐ General Anesthesia

Child presently ***has*** (mark with an 'X') or ***has had*** (mark with a '✓'):

_____ Colic	_____ Chicken Pox	_____ Measles	_____ Mumps	_____ Colds	
_____ Constipation	_____ Diarrhea	_____ Difficulty Sleeping	_____ Overactive	_____ Asthma	
_____ Skin Eruptions	_____ Vomiting	_____ Difficulty Breathing	_____ Frequent Crying		Headaches
_____ Ear Aches	_____ Ear Infections	_____ Poor Appetite	_____ High Fever		
_____ Feet Turn Out	_____ Feet Turn In	Other _____			

Falls (please give details): _____

_____

Accidents (please give details): _____

_____

Is he/she taking any medications: ☐ Prescription ☐ Over-the-counter

Please list medications: _____

Please list supplements / herbs / homeopathy / vitamins: _____

Operations: ☐ Ear tubes ☐ Tonsillectomy ☐ Heart ☐ Other _____

Vaccines: ☐ Yes ☐ No Current: ☐ Yes ☐ No

Does child consume wheat: ☐ Yes ☐ No Dairy: ☐ Yes ☐ No Caffeine: ☐ Yes ☐ No

Is child on a special diet: ☐ Yes ☐ No What type:_____

Past Chiropractic Care? ☐ Yes ☐ No Chiropractor's Name_____

I hereby authorize Dr. Carolin Kohler-Damron and/or whomever she may designate as her assistant to administer Chiropractic care as she deems necessary to my child.

Spouse or Guardian Signature_____ Date_____/_____/_____

Parent or Guardian (please print name) _____ Witness _____

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TERMS OF ACCEPTANCE

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra 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 a 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print your name)

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ ___ / ___ / ___
(Signature)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period __/__/__

_____ ___ /___ / ___
(Signature)