

# APPLICATION FOR CARE AT **UPWARD SHIFT CHIROPRACTIC**

Today's Date: \_\_\_\_\_

HR#: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birthdate: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Marital Status:  Single  Married Do you have insurance?  Yes  No

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

<b>Primary</b> or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Second</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Third</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Fourth</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when? \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_

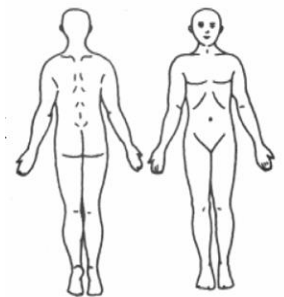
Name of previous chiropractor: \_\_\_\_\_  N/A

**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_  
\_\_\_\_\_

### PAST HISTORY

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state what type of treatment: \_\_\_\_\_, and who provided it? \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable  
Please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with:

**P** for in the **Past**      **C** for **Currently** have      **N** for **Never** have had

\_\_\_ Broken Bone    \_\_\_ Dislocations    \_\_\_ Tumors    \_\_\_ Rheumatoid Arthritis    \_\_\_ Fracture    \_\_\_ Disability    \_\_\_ Cancer  
\_\_\_ Heart Attack    \_\_\_ Osteo Arthritis    \_\_\_ Diabetes    \_\_\_ Cerebral Vascular    \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE IDENTIFY ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

### FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)?  No  Yes **If yes**, whom?  
 grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
2. Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

### SOCIAL HISTORY

1. **Smoking:**  cigars  pipe  cigarettes    How often?  Daily       Weekends       Occasionally       Never
2. **Alcoholic Beverage:** consumption occurs       Daily       Weekends       Occasionally       Never
3. **Recreational Drug use:**       Daily       Weekends       Occasionally       Never
4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See ADL form)

I hereby authorize payment to be made directly to **Upward Shift Chiropractic**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **Upward Shift Chiropractic** for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

**ACTIVITIES OF LIFE**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES:**

**EFFECT:**

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

**List Prescription & Non-Prescription drugs you take:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please mark: **P** for in the **Past**      **C** for **Currently** have      **N** for **Never**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Trouble Sleeping         | <input type="checkbox"/> Hepatitis (A,B,C)    |

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

**OTHER COMMENTS:**

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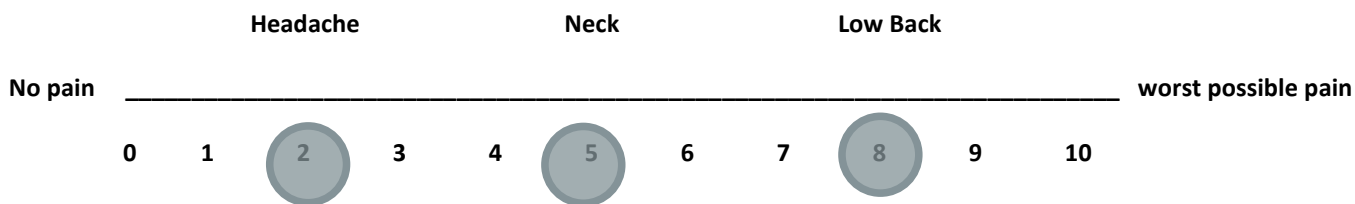
Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

**Please read carefully:**

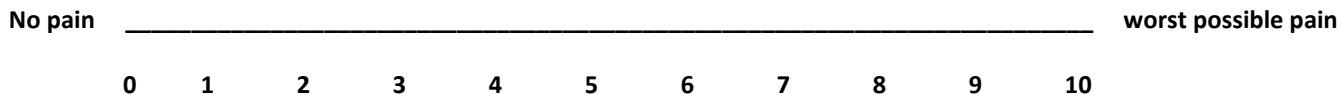
**Instructions: Please circle the number that best describes the question being asked.**

**Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.**

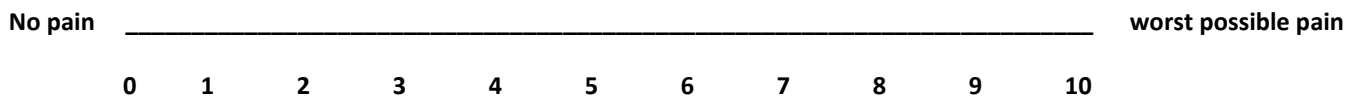
**Example:**



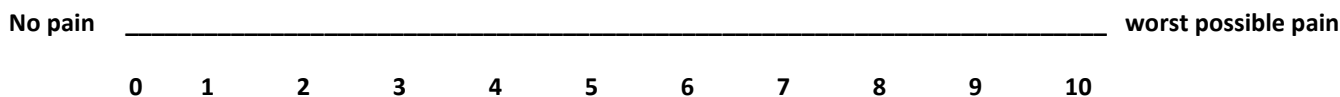
**1 – What is your pain RIGHT NOW?**



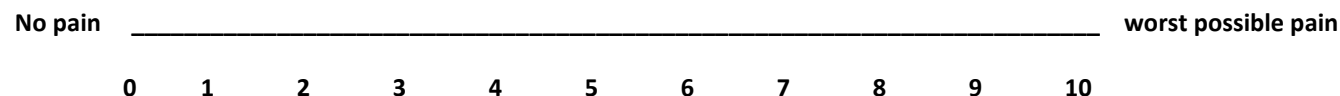
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



## UPWARD SHIFT CHIROPRACTIC

### Informed Consent

**REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at **Upward Shift Chiropractic** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Witness Initials

**REGARDING: X-rays/Imaging Studies**

**FEMALES ONLY:** *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

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 Name (print)

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Witness Initials

## UPWARD SHIFT CHIROPRACTIC 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 **Personal Health Information**. 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 a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) 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 apprise you of changes in practice hours or upcoming 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 "Detail" 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 us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Dan Taylor (239-231-2136). If he is unavailable, you may make an appointment with our receptionist to see him 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

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Information Release Form  
(HIPAA Release Form)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release of Information:**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages:**

Please call  my home  my work  my mobile number: \_\_\_\_\_

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- \_\_\_\_\_

The best time to reach me is (*day*) \_\_\_\_\_ between (*time*) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_



PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ Date: \_\_\_\_\_

## UPWARD SHIFT CHIROPRACTIC

### PEDIATRIC HISTORY FORM

Today's Date: \_\_\_\_\_

HR#: \_\_\_\_\_

#### PATIENT DEMOGRAPHICS

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_  Male  Female

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mother's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Father's Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Father's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Pediatrician/Family MD: \_\_\_\_\_ City/State: \_\_\_\_\_

Last Visit Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Reason for visit: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

Father's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mother's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Father's Driver's License #: \_\_\_\_\_

Mother's Driver's License #: \_\_\_\_\_

Other (*please explain*): \_\_\_\_\_

#### CHILD'S CURRENT PROBLEM

Purpose of this visit:  Wellness Check-up  Injury or Accident  Other

Please explain: \_\_\_\_\_

If your child is experiencing **pain/discomfort**, please identify where and for how long:

\_\_\_\_\_

\_\_\_\_\_

1. When did the problem first begin? Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  Unknown  Gradual  Sudden

2. Has this problem occurred before?  No  Yes If yes, when? \_\_\_\_\_

3. Any bowel or bladder problems since this problem began?  No  Yes **If yes**, describe: \_\_\_\_\_

\_\_\_\_\_

4. Have you seen any other doctors for this problem?  No  Yes **If yes**, whom? \_\_\_\_\_

5. How long ago? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

6. What were the results of past treatment? \_\_\_\_\_

7. How is this problem NOW?

Rapidly Improving  Improving Slowly  About the Same  Gradually Worsening  On and Off

8. Please list any medication(s) taken for this problem: \_\_\_\_\_

9. Has your child ever sustained an injury playing organized sports?  No  Yes **If yes**, please explain:

\_\_\_\_\_

\_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

10. Has your child ever sustained an injury in an auto accident?  No  Yes **If yes, please explain:**

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**HAS YOUR CHILD EVER SUFFERED FROM** - *Check all that apply*

- |  |  |  |   |
|--|--|--|---|
| <input type="radio"/> Headaches                | <input type="radio"/> Orthopedic Problems    | <input type="radio"/> Digestive Disorders        | <input type="radio"/> Behavioral Problems |
| <input type="radio"/> Dizziness                | <input type="radio"/> Neck Problems          | <input type="radio"/> Poor Appetite              | <input type="radio"/> ADD/ADHD            |
| <input type="radio"/> Fainting                 | <input type="radio"/> Arm Problems           | <input type="radio"/> Stomach Aches              | <input type="radio"/> Ruptures/Hernia     |
| <input type="radio"/> Seizures/Convulsions     | <input type="radio"/> Leg Problems           | <input type="radio"/> Reflux                     | <input type="radio"/> Muscle Pain         |
| <input type="radio"/> Heart Trouble            | <input type="radio"/> Joint Problems         | <input type="radio"/> Constipation               | <input type="radio"/> Growing Pains       |
| <input type="radio"/> Chronic Earaches         | <input type="radio"/> Backaches              | <input type="radio"/> Diarrhea                   | <input type="radio"/> Asthma              |
| <input type="radio"/> Sinus Trouble            | <input type="radio"/> Poor Posture           | <input type="radio"/> Hypertension               | <input type="radio"/> Walking Trouble     |
| <input type="radio"/> Scoliosis                | <input type="radio"/> Anemia                 | <input type="radio"/> Colds/Flu                  | <input type="radio"/> Sleeping Problems   |
| <input type="radio"/> Bed Wetting              | <input type="radio"/> Colic                  | <input type="radio"/> Broken Bones               | <input type="radio"/> Fall off swing      |
| <input type="radio"/> Fall in baby walker      | <input type="radio"/> Fall from bed or couch | <input type="radio"/> Fall from crib             | <input type="radio"/> Fall down stairs    |
| <input type="radio"/> Fall off bicycle         | <input type="radio"/> Fall from high chair   | <input type="radio"/> Fall off slide             |   |
| <input type="radio"/> Fall from changing table | <input type="radio"/> Fall off monkey bars   | <input type="radio"/> Fall off skateboard/skates |   |
| <input type="radio"/> Allergies to             |  |  |   |

Other:

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I understand that I am directly and fully responsible to **UPWARD SHIFT 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.

\_\_\_\_\_  
**Parent or Legal Guardian's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

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### AUTHORIZATION

I, \_\_\_\_\_ authorize the following individual(s),  
(Name of Parent or Legal Guardian)

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

to consent to medical treatment for my minor child/children listed below:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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### LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

\_\_\_\_\_  
\_\_\_\_\_

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

\_\_\_\_\_  
\_\_\_\_\_

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### PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date