

# Welcome to Chiropractic

Please Print Clearly and fill In completely.  
Infant (Newborn to 4)

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Emergency Contact and phone # (different from parent): \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Please Check  Sex: Male  Female  Right handed  Left handed

## Birth History:

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

Type of birth: Normal/Vaginal  Forceps  Breech  Caesarean  Suction

Delivered at: Hospital  Birthing Center  Home  Problems during pregnancy \_\_\_\_\_

Problems during Labor & Delivery \_\_\_\_\_

Apgar Scores \_\_\_\_\_ Jaundice (yellow) Yes  No  Cyanosis (blue) Yes  No

Congenital anomalies / Defects: \_\_\_\_\_

Infant feeding: Breast  Bottle  Formula  Quality of sleep: Good  Fair  Poor

# of hours of sleep per night: \_\_\_\_\_ Colic: Yes  No

Immunization history: \_\_\_\_\_

Childhood Illnesses / Diseases: Ear Infections  Chickenpox  Mumps  Measles

Rubella  Whooping Cough  Rubeola  Other: \_\_\_\_\_

Obstetrician: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

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

## Family History:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please feel free to mention below any health concerns you may have about your:

Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Are other family members under chiropractic care? Yes  No  Who? \_\_\_\_\_

## Childhood History

Research is showing that many of the health challenges that occur in life have their origins during the developmental years, some starting at birth. Please answer these questions to the best of your ability.

Do you have any childhood illnesses? Yes  No   
Did you have any surgery? Yes  No   
Prolonged use of medicines? I.e.: Antibiotics, inhalers, etc. Yes  No   
Any car accidents? Yes  No   
Any major falls? I.e.: Tree, seesaw, crib etc. Yes  No

### Wellness Commitment

At Billerica Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help your infant achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness for your infant.

10%\_\_20%\_\_30%\_\_40%\_\_50%\_\_60%\_\_70%\_\_80%\_\_90%\_\_100%

### Insurance Information (if applicable)

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
ID# \_\_\_\_\_ Policy # \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Billerica Chiropractic office will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Child's Name \_\_\_\_\_ Guardian's Name \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent To Treat Minor

I hereby authorize Billerica Chiropractic Office and those employed by same to administer chiropractic care as deemed necessary to my child, \_\_\_\_\_.

Child's name

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Billerica Chiropractic**

# Consent to Initiate Care

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, 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 it's 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 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 name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Date