Dr. Mariah's
Family Chiropractic Clinic
939 Avenue G
Fort Madison, IA 52627
Ph:319-246-1759
Fax:319-246-1760
Mfc_frontdesk1@hotmail.com

Patient Information:

Date: _____
Child's Name: _____ DOB: _____
Parent / Guardian's Name: _____
Home Phone #: _____ Cell Phone #: _____
Address: _____
E-mail Address: _____
Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No
If yes, please provide the name of the office & doctor. _____
Were x-rays taken ☐ Yes ☐ No
Who is your medical pediatrician? _____

Prenatal History:

Is your child adopted? ☐ Yes ☐ No
Did you have any complications and when? _____
Did you smoke? ☐ Yes ☐ No
Did you consume alcohol? ☐ Yes ☐ No
Did you take medication? ☐ Yes ☐ No
Reason for the medication? _____

Birth History:

Did you have ultrasound during this pregnancy? ☐ Yes ☐ No
What was the frequency? _____
Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital
Provider: ☐ Midwife ☐ OB-Gyn ☐ Other
Type of Birth: ☐ Vaginal ☐ C-section
Were pain medications used? ☐ Yes ☐ No
Was labor induced? ☐ Yes ☐ No
If yes, why? _____
What position did you deliver in? ☐ Squatting ☐ On back ☐ Other
Birth Trauma? ☐ Doctor assisted ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps
Newborn trauma (medical procedures and tests):
APGAR score: birth ____/10 5-minutes ____/10 ☐ Unsure
Did your child have a misshaped skull / head? ☐ Yes ☐ No
Were there purple markings on their face? ☐ Yes ☐ No
Did you breast feed your child? ☐ Yes ☐ No
Does your child prefer one breast over the other? ☐ Yes ☐ No
If yes, which side ☐ Right ☐ Left
Does your child have any food allergies? ☐ Yes ☐ No
If yes, please list: _____
Has your child been immunized? ☐ Yes ☐ No
Reason for vaccination? ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice.
Did your child have any negative reaction to the vaccinations? ☐ Yes ☐ No
Were they reported? ☐ Yes ☐ No
Has your child ever had any surgeries? ☐ Yes ☐ No
If yes, please elaborate. _____
Has your child been on antibiotics? ☐ Yes ☐ No
If yes, how often and what for? _____
Is your child currently taking any medication? ☐ Yes No
Is you child currently taking any vitamins? ☐ Yes No

Baby / Toddler (0-4):

Have any of the following occurred? Bald or flat spot-on head
Fall from a changing table Frequent crying spells Tumble down stairs Involvement in MVA table
Fall out of crib Fall off of playground Play in a Johnny Jumper Frequent ear infections
Bang their head equipment
Tonsillitis Arch their back Frequent fevers Frequent diarrhea
Constipation Sleeping problems Repeated infections Colic
Hold their head in certain position? Explain_____
(+ or -) weight gain Other (Please explain): _____

Child (5-12):

Have any of the following occurred?
Fall from a tree Fall off of a bicycle Sports accident Car accident
Stomach pains Scoliosis Bed wetting Fall on playground Hyperactivity / Autism
Learning difficulties Asthma Allergies Leg / Knee pains Other (Please explain):
_____

When did it begin? _____
Is it getting worse? Y N Yes No
Is the pain: Constant Intermit Cyclic Effect on activity? Not at all
Somewhat Always
Does your child participate in any of the following?

Soccer	Football	Gymnastics	Karate
Hockey	Lacrosse	Basketball	Dance
Wrestling	Baseball / Softball	Volleyball	Tennis
Swimming	Rugby	Other _____	

How would you rate your child's diet? Well balanced Average High sugar / processed foods
Does your child consume artificial sweeteners? Yes No
Fluoridated water? Yes No
Number of hours your child sleeps? _____hours per day
Sleep Quality? Good Fair Poor
What position does your child sleep in? _____
How are your child's bowel movements? (Frequency, consistency, ease) _____
Any rashes or skin changes? _____
****

Doctor's office use only

Infant Rooting (CNS) + -
Palmar Grasp (CNS) + - Toe In: Rt ____ Lt____ Bilat _____
Babinski Response + - Toe Out: Rt ____ Lt____ Bilat _____
Ortolani's (90° abducted) + - _____ "Bowleg?

"

Ventral Suspension - _____

Chest Symmetry Y _____

Symmetry of folds/creases_____

Head Circumference_____ Rt_____ Lt_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT FOR A MINOR

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read () or have had read to me () the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

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

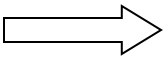
Name(s) and Address(es) of Office or Clinic Print Name(s) of Doctor(s) Treating this Patient
Dr. Mariah's Family Chiropractic, Fort Madison, IA Dr. Mariah Meller
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____
Printed name of Patient

_____ _____
Signature of Patients' Representative (if minor or physically incapacitated) Date

_____ _____
Witness to Patients' Signature Date

_____ _____
Translated by Date



Consent to Treat Patient – Without Parent /Legal Guardian Present By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____DOB: _____

For those occasions when you may not be with your child**, please list those individuals who may give us consent to see your child:**

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

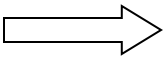
LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (if none, state "none")

□Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. This consent may only apply to minors age 16 and older.

This consent shall be in effect for:

□Date_____ (only)
□Indefinitely, until revoked by written communication



Mariah's Family Chiropractic

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 subluxation.

I have read and fully understand the above statements. 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.

Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Date

X-ray Release

This is to certify that the Drs. of Mariah's Family Chiropractic have my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____.

Signature Date

Consent to Care for Minor

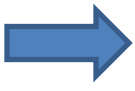
I authorize the Drs. of Mariah's Family Chiropractic and whomever they may designate as her assistant to administer care as she so deeds necessary to my son/daughter.

Signature Date

Insurance

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Mariah's Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mariah's Family Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

Signature Relationship to Patient Date



Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 1-319-246-1759. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

I understand this Cancellation/ Missed Appointment Policy

_____

Patient Signature

_____

Signature Date

_____

Printed Patient Name