Balanced Care Chiropractic

2500 W. Higgins Rd, Ste 965, Hoffman Estates, IL 60169

Office Use

F/C: ☐ INS ☐ MC ☐ MD ☐ IO ☐ WC ☐ AA ☐ PI ☐ SP BCC# _____

Included: ☐ Insurance Card Copy ☐ Employer Claim Form ☐ Referral/Script

ABOUT YOU

Date: _____/_____/_____

Childs Name - First: _____ **Last**: _____

Preferred Name: _____ Date of Birth: ____/____/_____ Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ ZIP: _____

E-Mail: _____ Cell #: _____ Other #: _____

Emergency Contact: _____ Relation: _____ #: _____

Height: _____ft. _____in. Weight: _____lbs.

Name of Parents/Guardians: _____ Referred By: _____

# of Siblings: _____ Names: _____

INSURANCE INFO

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____ Birthdate:_____

Person Ultimately Responsible for account: Name: _____Phone: _____

Please inform front desk of any 2nd Insurance source

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection with expenses as the result of doctor services.

Patient Signature: _____ Date: _____

REASON FOR VISIT

Briefly describe your child's symptoms:_____

How did the symptoms start:_____

Symptoms began on? _____

Average pain intensity: (please circle your answer)

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

How often does your child experience the symptoms?

1.Constantly (75%-100% of the time) 2.Frequently (51%-75%) 3.Occasionally (26%-50%) 4.Intermittently (0%-25%)

How much have the symptoms interfered with your child's usual daily activities?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Is this condition getting worse: Yes No Constant Comes and goes

If so, please explain: _____

Have they had this or similar conditions in the past? Yes No

If so, please explain: _____

Have they been treated by a Medical Professional for this condition? Yes No

If so, where? _____ When? _____

In general, would you say their overall health right now is… Excellent Very good Good Fair Poor

HEALTH HISTORY

Circle any of the Following Conditions Your Child has suffered:

Ear Infections	Bedding Wetting	Temper Tantrums
Seizures	Asthma	Headaches
ADHD	Colic	Growing/Back Pain
Car Accident	Scoliosis	Severe Illness
Chronic Colds	Digestive Problems	Allergies to…_____
Surgeries	Recurring Fevers	Other_____

If yes to any, please give date and details:_____

Are Vaccinations Current? ___N ___Y

Family History: _____

Previous Chiropractor: _____Date of Last Visit: _____ Reason: _____

Number of Doses **of Antibiotics or other Prescriptions** Your Child has Taken:

*During the Past Six Months:_____, Total During His / Her Lifetime: _____ List:_____

Number of Hours Sleeping per Night: _____ Sleep Quality: Good Fair Poor

--According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of lift (i.e., a bed, changing table, down stairs, etc.)
Was this the case with your child? ___N____Y

--**Is or has your child been involved in any sports** (i.e., soccer, football, gymnastics, martial arts, etc)? ___N____Y

List:_____ Any injuries? ___N___Y List _____

PRENATAL/DEVELOPMENTAL HISTORY (under Age 5)

Name of Obstetrician / Midwife: _____

Problems During Pregnancy? ____N ____Y, List: _____

Ultrasounds During Pregnancy? ____N ____Y, Number: _____

Medications During Pregnancy / Delivery? _____N _____Y, List: _____

Cigarette / Alcohol Use During Pregnancy: _____N ____Y

Location of Birth: _____ Hospital _____ Birthing Center ____ Home

Birth Intervention: ____ Forceps ____ Vacuum Extraction _____Cesarean, Emergency or Planned?

Problems During Delivery ? ____ N ____Y, List: _____

Genetic Disorders or Disabilities: ____N ____Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).
At what age was your child able to:

_____ Respond to Sound
_____ Follow an Object
_____ Hold Head Up
_____ Vocalize
_____ Sit Up
_____ Crawl
_____ Stand
_____ Walk

FEEDING HISTORY (under age 5)

Breast Fed? ___N ___Y, How Long: ____**Formula Fed?** ___N ___Y, How Long:____ Type: _____

Introduced to Solids at: _____Months, Cows' Milk at _____Months

Food / Juice Allergies or Intolerances: ____N ____Y, List: _____

OFFICE POLICIES & TREATMENT OF A MINOR

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Your health insurance is a contract between you and your insurance carrier. I understand I am totally responsible for all services rendered at Balanced Care Chiropractic, LLC, even if my insurance company denies payment for any reason.
- **All cancellations & reschedules require 12 hour notice or a $30 fee will be charged. Insurance will not cover.**
- **"No Shows" will be subject to a $30 fee before rescheduling. Insurance will not cover.**
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I as legal guardian of the patient do authorize appropriate chiropractic treatment.

Signature Parent or Guardian: _____ Date:_____

Print Name: _____