VANELLA CHIROPRACTIC

"Helping families get well and stay well for a lifetime."

Child's Name			Sex: □ M □ F
DOB:	AGE:	Height:	Weight:
Parent/Guardian's Name:			
Address			Zip code:
Email:		Cell Phone:	
How did you hear about us?			

HEALTH GOALS FOR YOUR CHILD

Circle all of the following that best describe your child's overall health goals?

Stronger Immunity	Better Sleep	Improved Digestion	Less Pain
Injury Prevention	Improved Posture	Improved Concentration	Less Medicine
Imprved Breathing	Other: _____		

What results are you hoping to experience by working with our office? _____

_____

How long do you anticipate it taking to reach these results? _____

What do you feel is causing your child's health concerns? _____

Has your child every received chiropractic care? Yes / No With whom? _____

HEALTH HISTORY

Please list any diagnosed health conditions: _____

Please check any of the following that pertain to your child:

Ear Infections	Scoliosis	Seizures	Chronic colds	Asthma
Digestive problems	Allergies	ADD/ADHD	Recurrent Fevers	Colic
Bed wetting	Headaches	Growing pains	Motor problems	Neck pain
Behavior problems	Trouble sleeping	Speech difficulties	Autism spectrum	Back pain
Concussion	Whiplash	Other: _____		

What medications does your child take? _____

What supplements does your child take? _____

Please list any surgeries yor child has had: _____

Please list any complications during pregnancy & delivery: _____

Please list any injuries/accidents your child has had: _____

Has your child every had adverse reactions to vaccinations: _____

What other information about your child's health we should be aware of? _____

_____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic thermography, surface emg, and HRV by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I

I do hereby designate Dr. Michael Vanella and Vanella Chiropractic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b) 4 to otherwise 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 health care expense(s) incurred as a result of the services I receive from the above names doctor. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance including co-pays and deductibles.

_____ _____

Patient Signature Date