8678 19th St, Suite #130
Rancho Cucamonga, CA 91701

Tel: (909) 483-5433
Fax: (909) 483-6633

www.sartinhealth.com

Pediatric/Adolescent Health History

Date _____
Name _____
Nickname _____
Birthday ____/____/_____ Age _____
Social Security # _____
Address_____
_____
City _____ State _____ Zip _____

Parent Name _____ # _____
Parent Name _____ # _____
Home Phone _____
Email _____

Emergency Contact Info
Name_____ # _____
Relationship to Patient _____

Pregnancy, Labor & Delivery History

Did you Carry Full Term? No Yes How many weeks? _____

Were there any complications/concerns during pregnancy? (Explain)_____
_____
_____

Did you have any Ultrasounds? No Yes How many? _____
Did you use a: Midwife Obstetrician Location of Birth? Home Birthing Center Hospital
Name of Midwife/Obstetrician _____ Tel # _____

Birth Intervention: Induced No Yes
Epidural? No Yes
C-section No Yes → Planned or Emergency (Explain) _____
Forceps No Yes _____
Vacuum No Yes _____

Did you have any complications during labor and/or deliver? (Explain) _____
_____

Did you smoke during your pregnancy? No Yes How Much? _____
Did you consume alcohol during your pregnancy? No Yes How Much? _____
Did you take any medication during your pregnancy? No Yes How Much? _____
Please list medications _____

What was the baby's APGAR score? _____
Did you breastfeed? No Yes → How long? _____ If no, why? _____
What formula did you use? _____
Does your child have any allergies/intolerances? _____
_____

Birth to 4 years

Traumas (Please Select All that Apply)

- ☐ Fall from change table
- ☐ Tumble down stair(s)
- ☐ Fall out of crib
- ☐ Involved in a car accident
- ☐ Fall off playground equip.
- ☐ Play in "Jolly Jumper"
- ☐ Frequent ear infections
- ☐ Tonsillitis/bronchitis
- ☐ Reaction to vaccination
- ☐ Reaction to medication
- ☐ Frequent fevers
- ☐ Frequent bouts of diarrhea
- ☐ Constipation
- ☐ Sleeping problems
- ☐ Frequent colds
- ☐ Colic
- ☐ Difficulty gaining weight
- ☐ Other _____

Please Explain: _____

_____

_____

Developmental History

At birth the spine and nervous system are not fully developed and are therefore extremely vulnerable to stress. Routine check-ups by a Doctor of Chiropractic are extremely beneficial in prevention and early detection of spinal nerve interference. At what age was your child able to:

- _____ Respond to sound
- _____ Respond to visual stimuli
- _____ Hold head up
- _____ Roll over
- _____ Sit Up
- _____Cross Crawl
- _____ Stand Alone
- _____ Walk Alone

5 to 12 years

Traumas (Please Select All that Apply)

- ☐ Fall from tree
- ☐ Fall off bicycle
- ☐ Fall off playground equip.
- ☐ Sports accident
- ☐ Car accident
- ☐ Stomach Pains
- ☐ Scoliosis
- ☐ Bed Wetting
- ☐ Hyperactivity/ADHD/ADD
- ☐ Learning difficulties
- ☐ Asthma
- ☐ Allergies
- ☐ Leg/knee pains
- ☐ Other _____

Please Explain: _____

_____

_____

Child/Adolescent

Has your child experienced any of the following:

- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Asthma
- ☐ Fatigue
- ☐ Numbness
- ☐ Upper extremity pain
- ☐ Lower extremity pain
- ☐ Neck/Back pain
- ☐ "Growing Pains"
- ☐ Sleeping problems
- ☐ Allergies
- ☐ Stomach Problems
- ☐ Weight gain/loss
- ☐ Hyperactivity

Please Explain: _____

_____

_____

Has your daughter reached menarche? No Yes → What age? _____

Does she have any troubles with menses? (irregular, heavy, pain etc.) _____

_____

_____

Vaccinations

Please list all vaccinations your child has received, as well as at what age. If they have received all vaccinations on the CDC vaccination schedule, please let us know, you do not have to list all of them. Please note any adverse reactions.

_____

_____

_____

_____

_____

_____

***Please let us know if you would like information on both the pros and cons of vaccinations, and what your rights are as a parent or guardian.

Medications & Antibiotics

Please note any medications and antibiotics your child is currently on, as well as those he/she has taken on a regular basis even if he/she is no longer taking them. Please note the purpose of the medication, and any adverse reactions. (Please include prescribed and over-the-counter)

_____

_____

_____

_____

_____

_____

***Please let us know if you would like information on both the pros and cons of vaccinations, and what your rights are as a parent or guardian.

Childhood Diseases & Conditions

Has your child ever been diagnosed with:

- ☐ Chicken Pox → Age _____
- ☐ Rubella → Age _____
- ☐ Measles →Age _____
- ☐ Mumps → Age _____
- ☐ Whooping Cough → Age _____
- ☐ Autism → Age _____
- ☐ ADD/ADHD → Age _____
- ☐ Other → Age _____

Please explain, and describe any actions taken: _____
_____
_____
_____

Emergencies & Surgeries

Has your child ever been to emergency? No Yes → Explain _____
_____
_____

Has your child ever had any hospital stays? No Yes → Explain _____
_____
_____

Has your child ever experienced any other traumas not yet described? No Yes → _____
_____
_____

Purpose of Your Visit

What is the main purpose of today's visit? _____
_____
_____

How long has this concern persisted? Please Explain _____
_____
_____

Is this problem: Constant Intermittent Occasional Cyclic

Have you done anything to help relieve this concern? No Yes → Explain _____
_____
_____

Has this affected their daily activities? No Yes → Explain _____
_____
_____

Previous Chiropractic Care

Has your child ever been to a chiropractor? No Yes

If so, when? _____ why? _____

_____

Is there anything else you feel we should know?

_____

_____

_____

_____

_____
Name of individual completing form (Printed)

_____
Relationship to patient

_____
Signature

_____
Date Signed

FOR DOCTOR'S USE ONLY

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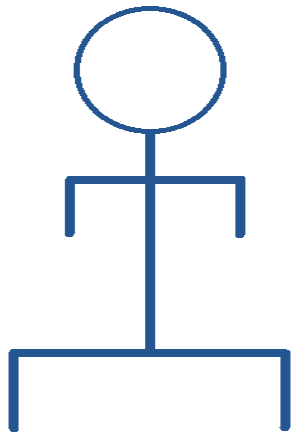

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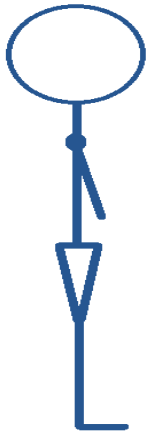

EXAM FINDINGS

HISTORY

Financial Agreement

I, _____, clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient Signature Date Guardian or Spouse Signature Date

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp.

☐ Medicare ☐ Personal Health Insurance ☐ Auto Insurance

Emergency Contact

Name _____

Relationship _____

Work Phone (___)_____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide an necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____ Policy # _____

Address _____ Group # _____

Phone # (___)_____

Office Fee Schedule and Financial Policy

Service	**Fee**
Consultation	$ 30
Initial Exam/Computer Scans	$ 125
Dynamic Re-exam/Computer Scans	$ 40
X-Rays	$ 75
Adjustments	$ 50
Wellness Adjustment Plans	?

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstanding in the future. Our main concern is your health and well being, and we will do our best to help you.

IMPORTANT: All client's, are responsible for full payment for the first visit, unless other arrangements have been made in advance.

Today's payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Insurance: We will verify all insurance and your benefits per your agreement with you carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. *Please let the Chiropractic Assistant know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.*

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Abundant Life Chiropractic with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

_____ _____

Patient's Name Patient's Signature

Date: ____/____/_____ _____

Witness

Missed Appointment Policy

Here at Abundant Life Chiropractic, we strive to provide you with the utmost professionalism and excellence of service. Our commitment to your health and well-being is something we take very seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need, and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results

- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment please call our office and arrange for a make-up appointment with our Chiropractic Assistants. We would prefer the make-up appointment be within the same week.

In the instance of a rescheduled appointment, or a no show without notice by phone we reserve the right to charge you a $20.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all of the information written above.

_____ _____

Patient's Name Patient's Signature

Date: ____/____/_____

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic (**Dr. Cory Sartin, Dr. Dani Sartin**) and/or his/her preceptor and/or other licensed doctors of chiropractic 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 including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, Abundant Life Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with information that provides a more complete description of information uses and disclosures. I understand that I have the right to review this information prior to signing this consent. I understand that Abundant Life Chiropractic reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Abundant Life Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Abundant Life Chiropractic has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Patient Name (Printed)	Date Signed
_____	_____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)	Witness to Signature
_____	_____
Doctor of Chiropractic Signature	Date Signed