



Did you notice any differences, difficulties or skipping of some of the following stages (if applicable):

Response to Sound  Hold Head Up  Sit Up  Rolling Over  Self Feeding  Walking Alone  Cross Crawl  Stand Alone  
 Walking Alone  Talking

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Cheerleading, Martial Arts, etc)? If yes, please list: \_\_\_\_\_

Has your child had previous chiropractic care?  Yes  No If yes, please list last visit date: \_\_\_\_\_

Has your child ever been involved in a car accident?  Yes  No If yes, please list date: \_\_\_\_\_

Prior Surgeries?  Yes  No If yes, please list surgery type and date: \_\_\_\_\_

Prior Hospitalization?  Yes  No If yes, please hospitalization list type and date: \_\_\_\_\_

Are there any other parental concerns? \_\_\_\_\_

Childhood Diseases (Please circle all that apply): Chicken Pox, Measles, Mumps, Rubella, Whooping Cough,  
Other: \_\_\_\_\_

### Payment Information

**Please have your photo ID ready so it can be copied for the clinic's records.**

Person Responsible for Payment: \_\_\_\_\_ Phone: \_\_\_\_\_

**Financial Responsibility:** I understand that most insurance policies do not cover wellness chiropractic care for children. I understand that any treatment provided, that is not covered by health insurance, I am solely responsible for. This includes all fees and charges associated with this assessment and any future treatment provided by Carolinas Chiropractic and Spinal Rehab, regardless of insurance or extended health coverage.

### Office Policies

Re-Exam Policy - If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed they will be subject to a re-examination and a subsequent re-exam charge.

Cell Phone Policy - In an effort to keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.

Cancellation Policy - We understand that there are emergencies and we will be sensitive to those issues; however we respect your time and ask that our time be respected as well. Please be advised that there is a \$40 fee for all missed appointments without sufficient notice. Please notify us by 2:00pm on the business day prior to your scheduled appointment to avoid a fee.

Children in the Office Policy - While we welcome children in our office, we do ask that you have an adult available to accompany them should they need to step out of the exam room or wait in the waiting room.

**I, the undersigned, understand and agree to the above and, in order to be accepted as a patient in this office, agree to abide by these policies.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent for Treatment

**By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient**

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_