

GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

- | | | | |
|--------------------------|--|--------------------------|--|
| Past | Present | Past | Present |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Colic | <input type="checkbox"/> | <input type="checkbox"/> Chronic Colds/Sinus |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> | <input type="checkbox"/> ADHD/Spectrum Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> | <input type="checkbox"/> Delayed Developmental Milestones
(trouble walking or crawling) |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ | | |

1. Vaccinations: Up to date Delayed Schedule None
 2. List any medications being taken: _____
 3. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
 4. Name of Pediatrician and Other Doctors: _____
 5. Date of Last Visit ____/____/____ Reason: _____
 6. Name of Obstetrician/Midwife (If under 5 y.o.) _____
 7. Location of Birth: Hospital Birthing Center Home
 8. Complications During Pregnancy or Delivery: No Yes
- Explain: _____
9. Mode of Delivery: Vaginal Cesarean Forceps Vacuum
 10. Was an induction performed: No Yes
 11. Were any of the following received: Epidural Pain meds
 12. Ultrasounds During Pregnancy: No Yes How Many: _____
 13. Medication During Pregnancy No Yes List: _____
 14. Cigarette / Alcohol Use during Pregnancy: No Yes
 15. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": No Yes, Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____

16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Is there any other family history you want us to know? _____

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Cell Phone _____ Marital Status: _____ Gender M F Significant Other's Name _____
 Have you been to a chiropractor before? No Yes When was your last Chiropractic Appointment? _____
 Your Employer _____ Type of Work _____
 E-Mail Address _____ Who Referred you to us? _____
 Emergency Contact _____ Ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- Understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

 Patient / Parent Signature (This represents a long term authorization for all occasions of service) _____ Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
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3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

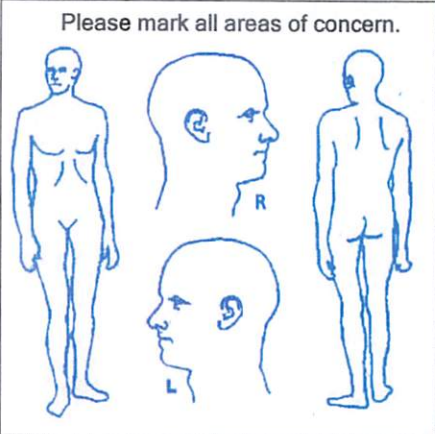
9. Type of treatment: _____

10. Results: _____

NOTES: _____

Are you pregnant?
 Yes No
 How far along? _____
 Due Date: _____

Please mark all areas of concern.



Paying for your care is easy here!



Initial which one is you:

No Insurance:

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like Lasik, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial _____

Health Insurance:

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial _____

Auto Injury

- Most Auto related injuries are covered 100% in Ohio for patients not at fault. You can get the care you need and it normally costs nothing. Great for you!
- All we need is your claim number and insurance information.

Initial _____

Medicare

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial _____

You have made a great decision to get care here!
Our goal is to be your family chiropractor for life!

Informed Consent

Section 1: Informed Consent for Chiropractic Care

We are committed to providing you with safe, effective, and natural chiropractic care. Please read this form carefully.

What is Chiropractic Care? Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints to improve alignment, movement, and overall function.

What to Expect During Your Care:

- Thorough health history and physical exam (posture, movement, muscle strength, etc.).
- X-rays may be recommended.
- Personalized care plan that may include adjustments, soft tissue therapies, exercises, or referrals if needed.

Benefits of Chiropractic Care:

- Reduced pain or discomfort in back, neck, or joints
- Improved mobility, flexibility, and posture
- Enhanced overall wellness, energy, and physical performance

Understanding Rare Risks: Chiropractic care is very safe, but like any healthcare approach, there are rare risks:

- Temporary soreness or discomfort after adjustments
- In very rare cases, minor muscle or ligament strain
- Extremely rare risks involving neck adjustments (estimated at less than 1 in 1 million)

What Happens if You Choose Not to Pursue Care?

You may continue to experience discomfort, limited mobility, or other symptoms. Untreated issues could worsen over time.

Other Care Options: Rest, over-the-counter pain relievers, physical therapy, medications, injections, or surgery.

Section 2: SoftWave (ESWT) Suitability Questions

Please **answer** the following to help us determine if SoftWave Tissue Regeneration is appropriate for you:

- Have you been injected with cortisone this month? Yes / No
- Have you been diagnosed with cancer/tumor within the last 12 months? Yes / No
- Have you been diagnosed with a skin infection in the last 12 months? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

Our Commitment to You We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

Section 3: Decompression Suitability

Please **circle** any that apply to you:

- Pregnant • Metal implants in spine • Advanced Osteoporosis • Hernia • Blood Thinners • Spinal Fusion • Fractured or Broken Vertebra • Failed Back Surgery • Tumor • Cardiac or Pulmonary Disease • Abdominal Aortic Aneurysm
- Other (related to today's treatment):

Your Rights and Responsibilities:

Your Right to Choose: You can stop or modify your care plan at any time. Just let us know what you're comfortable with.

Your Responsibility: Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.

Photos and Text Reminders: By signing this form, you also agree to the following (please cross out any that you want to opt out of):

Photos for Social Media: I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time.

Text Appointment Reminders: I agree to receive text reminders for my appointments to help me stay on track.

Your Consent: By signing below, I confirm that: I have read and understood this form, and my questions have been answered to my satisfaction. I understand the benefits, rare risks, and alternatives to chiropractic care.

I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.

I understand I can stop or change my care plan at any time.

Patient Name (Printed):

Patient Signature:

Date: _____

Parent/Guardian Name (if applicable):

Parent/Guardian Signature:

Date: _____

