



TCA PEDIATRIC FORM

1240 North Pitt St # 100
Alexandria, VA 22314
703-739-0456
www.chiropractic.net

PATIENT INFORMATION:

Name: _____ Social Security: _____
Address: _____
City: _____ State: _____ Zip: _____
Age: _____ Date of Birth: _____ Weight: _____ Height: _____
Parent Name: _____
Mother's Telephone: _____ Father's Telephone: _____
Referred By: _____

CHILD'S MEDICAL HISTORY:

Have your child had chiropractic care previously? _____
If so, How long ago? _____ Previous Chiropractic Dr.: _____
Present Complaint: _____
When did this begin? _____ Was any accident involved? _____
If so explain briefly: _____

Complications during pregnancy? If yes, please explain: _____
How many times has your child been prescribed antibiotics in the past? _____
Has your child received vaccinations? If yes, please explain: _____

Please check if your child currently has or has ever had any of the following: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hormone disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent stomachaches |
| <input type="checkbox"/> Eczema - Hives | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Blood pressure concerns |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> chronic illnesses | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Weight loss |

Other not listed above: _____

Breast Fed? Y/N, Explain: _____

Formula Fed ? Y/N, Explain: _____

Introduced to solids at what age? _____ Any food allergies? _____

Has your child ever had any major fall/ head trauma or sport injuries? Y/ N, Explain: _____

Briefly describe sleep patterns: _____



Consent to evaluate and Muscle Test a minor / child

I, _____ the undersigning parent /guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. _____

and whomever he/she might designate as assistant to perform in judgment and examination and muscle testing.

Any specific authorization you provide may be revoke at any time by writing to us at the address provided on the front of the form.

Patient: _____ Signature: _____ Date: _____
Parent/ legal Guardian _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Emergency Contact: _____

Phone Number: _____

THE CHIROPRACTIC ASSOCIATES

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working with the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

As a chiropractic patient, it is important that you are always aware of some terminology that will be used in practice. This will give you a better understanding of chiropractic care.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if, during a chiropractic spinal examination, we encounter non-chiropractic or usual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference in the expression of the body's innate wisdom to heal itself. Our only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor / child:

I, _____, Being the patient or legal guardian, have read and fully understand the above terms of acceptance and hereby grant permission of my child to receive chiropractic care.

PLEASE SIGN BACK

MISSED APPOINTMENTS / CANCELLATIONS POLICY

WE PROVIDE SERVICES BY APPOINTMENT ONLY

IF YOU CANNOT MAKE YOUR APPOINTMENT,
PLEASE GIVE US 24 HOURS NOTICE TO AVOID BEING
CHARGED \$50.00 FOR THE TIME YOU HAVE RESERVED

IF YOU NEED A DETAILED REOPT OR TREATMENT
OR FOR AN ACCIDENT CASE, AND ADDITIONAL FEE OF \$80.00
WILL BE CHARGED.

PATIENT NAME:

PATIENT SIGNATURE:

DATE:
