YOST Family Chiropractic
3993 100th Street • Urbandale, IA 50322 • 515.278.YOST
www.YostFamilyChiropractic.com

Child's Name:_____ Date:_____ Referred By:_____
Address:_____ City:_____ State:_____ Zip code:_____
Date of Birth:_____ Age:_____ Gender:_____
Mother's Name:_____ Mother's Cell:_____ Work Phone:_____
Father's Name:_____ Father's Cell:_____ Work Phone:_____
List Ages of Other Children in Family:_____
Pediatrician's Name:_____ Clinic Name:_____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here? Y N N

Demographics: Language _____(Primary)
Race: Unspecified_____ American Indian or Alaska Native _____ Black or African American _____ Other_____ White_____
Ethnicity: Not Hispanic or Latino _____ Hispanic or Latino _____ Unspecified_____
Would you like reminders for future appointments? If so, ☐ TEXT, ☐ EMAIL, or ☐ NONE? (Circle One)
* **Phone Carrier** _____ **Email** _____

Labor & Delivery

Third Trimester Presentation: Vertex ☐ Breech ☐ Transverse ☐ Face/Brow ☐
Type of Birth: Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap/Vacuum ☐
Location: Home ☐ Birthing Center ☐ Hospital ☐ # Hours in Labor:_____ Pushed for: ____min.
Problems during pregnancy:_____
Problems during labor/delivery:_____
Were any medications administered at birth?_____
Apgar Scores: _____ _____ At the time of birth, was the child: jaundice (yellow)? Y N Cyanosis (blue)? Y N
Birth weight: _____ Birth Height:_____ Current weight:_____
Did the mother use any cigarettes, alcohol, or medications during pregnancy? Y N
Congenital Anomalies/Defects? Y N If yes, please explain:_____

Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

☐ Measles, Mumps	☐ Headaches	☐ Stomach Aches
☐ Chicken Pox	☐ Dizziness	☐ Reflux
☐ Eczema/Skin problems	☐ Fainting	☐ Diabetes
☐ Pneumonia	☐ Seizures/Convulsions	☐ Hypertension
☐ Asthma/Wheezing	☐ Heart Trouble	☐ Anemia
☐ Cancer	☐ Orthopedic Problems	☐ Bed Wetting
☐ Hepatitis	☐ Neck Problems	☐ Behavioral Problems
☐ Allergies	☐ Joint Problems	☐ ADD/ADHD
☐ Frequent Colds/Sore throat	☐ Scoliosis	☐ Ruptures/Hernia
☐ Diarrhea	☐ Walking Trouble	☐ Growing Pains
☐ Constipation	☐ Broken Bones	☐ Sleep Problems
☐ Colic	☐ Digestive Disorder	☐ Speech Problems
☐ Ear Infection	☐ Poor Appetite	☐ Emotional Problems

Please list any medications or supplements your child is currently on:_____

Number of doses of antibiotics your child has taken in his/her history:_____

Has your child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall of monkey bars
- ☐ Fall of skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other: _____

Date of last visit to pediatrician: _____ Purpose of visit: _____

Y N Has your child ever been treated on an emergency basis? _____

_____

Y N Did you choose to vaccinate your child? If yes, which vaccines? _____

_____

At what age did your child:

_____ Respond to Sound _____ Follow an object with his/her eyes _____ Hold head up

_____ Sit alone _____ Crawl _____ Stand _____ Walk alone

The following questions are designed to allow the doctor to provide a detailed evaluation of your child. If a question is not relevant to your child's age, please put "N/A"

Y N How many hours does your baby sleep between feeds? During day _____ At night _____

Y N Does your child go to sleep easily? _____

Y N Does child have a preferred sleeping position? _____

Y N Does child cry if you change this sleeping position? _____

Y N Does your child have any difficulties feeding? _____

Y N Is baby being breast fed? If no, for how long was baby breast fed? _____ Weeks/months

Y N Does baby have a one sided breast feeding preference? Preferred breast Left / Right

Y N Is your child formula fed? Which formula or other milk source? _____

Y N Does baby frequently spit up after feeding? _____

Y N Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Y N Does your child have any food allergies? _____

Y N Does your child cry a lot? For how many hours each day? _____

Y N Does baby pass a lot of intestinal gas? _____

Y N Does baby have a preferred head position? _____

Y N Does baby frequently arch his/her head and neck backwards? _____

Y N Does baby cry or become irritable during a diaper change? _____

Y N Does your child refuse to make eye contact? _____

Y N Does your child ever band his/her head against a wall repeatedly? _____

Do you have any other concerns you want to discuss? _____

Y N Has your child ever received chiropractic care? If yes, who? _____

What were the results? _____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Child's Name: _____

Guardian Signature: _____ Date: _____

Informed Consent:

CHIROPRACTIC: 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 name of the patient below, for whom I am legally responsible for) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future with at Yost Family Chiropractic Inc.

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. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that known to him or her, is in my best interest. I understand that results are not guaranteed. I have read the above consent. I understand I have the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information. *(Request a copy if needed.)*

ACUPUNCTURE: Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment.
Side Effects: The following side effects may occur and are not limited to the following:

a. Some pain following treatment in the insertion location (uncommon).
b. Minor bleeding from insertion location (occasionally).
c. Minor bruising (occasionally).
d. Infection (rare).
e. Needle sickness (feeling faint or dizzy, rare).
f. Broken needle (almost unheard of).

(Not to mention are many other potential side effects of treatment which are much more common: acquisition of a deeply relaxed state, drugless relief of your condition, enhanced well being, improved immunity and increased mental clarity and insight.)

Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

MASSAGE: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massageon anyone whom she deems to have a condition for which massage is contraindicated.

With this knowledge, I give my informed and voluntarily consent to the above procedures:

Print Patient Name: _____ Date:_____

Patient or Guardian Signature: _____

Authorization, Release & Financial Polices:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage.

I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. The following person(s) have my permission to receive my personal health information:

_____ _____

I do understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for services provided to me by the chiropractor. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card given at time of check in. If payment hasn't been received in 10 days from terminating any care, I authorize deduction from my credit card. PLEASE NOTE: Insurance companies do not pay for care that is not medically-necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage. I agree to allow Yost Family Chiropractic to use my picture/my child's picture for publication in printed advertisement and/or website.

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Missed Appointment Policy

Thank you for choosing Yost Family Chiropractic for your health & wellness care. As a client of this practice, please know that we will strive to give you the best care. To accomplish our goal and meet your needs, the following policy applies:

You are responsible for providing a valid credit card number in order to schedule any appointment, including chiropractic, massage, and acupuncture, with Yost Family Chiropractic. This credit card guarantees your appointments with YFC and you will not be charged unless you fail to attend your appointment or do not give us at least 24-hour notice to reschedule. A failure to comply with this policy will result in your card being charged for a $30 appointment fee. For your convenience, we accept all major credit cards.

I understand and agree to the above policy. By signing below I authorize deduction from my credit card on file if I fail to follow this policy.

Printed Name: _____ Date: _____

Signature: _____