Ethos Regenerative Medical Group Child Health Information

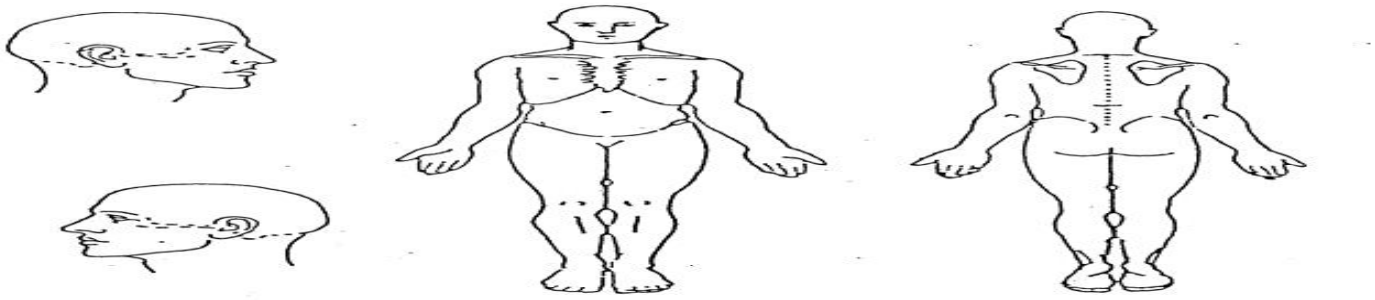
Today's Date: ___ / ___/ _____ Who can we thank for referring you? : _____
Child's Name: _____ Male Female Date of Birth: _____
Mother's Name:_____ Father's Name:_____
Street Address: _____City: _____ State: ____ Zip Code: _____
Parents E-mail Address: _____
Parents Cell Phones: _____

What are your Main Reasons for consulting with our office today? (Please list in order of importance)
1) _____ When did issue begin? _____
2) _____ When did issue begin? _____

Other Providers seen for this condition: Yes No.
Dr. Name and the diagnosis: _____

Is Child in Pain or Discomfort today? ☐ Yes ☐ No

Mark on the diagram the area of your body



What do you believe CAUSED your health problems? _____

Any other areas of complaints you would like to discuss with Dr. Black:_____

Answer for children: Ages Birth to 12 Months
Breast Fed ☐No ☐ Yes How long:_____ Introduced Solid foods at what month: _____
Food sensitivities, allergies, or intolerances ☐ No ☐ Yes List:_____

Mother's Wellbeing during Pregnancy: Mom was healthy during pregnancy ☐ Yes ☐ No _____

Approximately how long was the labor? _____Was it chemically induced? ☐ YES ☐ NO
Was a C-section performed? ☐ YES ☐ NO Were forceps used? ☐ YES ☐ NO Vacuum used? ☐ Yes ☐ No
Was the baby premature? ☐ YES ☐ NO If yes, what was his/her age and weight when born_____.

Does child suffer from any of the following currently or in the past: "C" for currently or "P" past

Heart Problem	☐ YES C P	☐ NO		Fainting/ Seizures	☐ YES C P	☐ NO	
Joint Problems	☐ YES C P	☐ NO		Diarrhea	☐ YES C P	☐ NO	
Headaches	☐ YES C P	☐ NO		Constipation	☐ YES C P	☐ NO	
Ear Infections	☐ YES C P	☐ NO		Blood Pressure	☐ YES C P	☐ NO	
Sleep disorders	☐ YES C P	☐ NO		Allergies/ Sinus	☐ YES C P	☐ NO	
Breathing trouble	☐ YES C P	☐ NO		Fatigue	☐ YES C P	☐ NO	
Colic	☐ YES C P	☐ NO		Skin/ Rashes	☐ YES C P	☐ NO	
Frequent cold/flu	☐ YES C P	☐ NO		Bed wetting	☐ YES C P	☐ NO	
Poor Appetite	☐ YES C P	☐ NO		Hyperactivity	☐ YES C P	☐ NO	
Bloody noses	☐ YES C P	☐ NO		Colic	☐ YES C P	☐ NO	

Please check ALL which suffer or are more difficult as a result of your health complaints:

□ Sports	□ Family Time	□ Cleaning	□ Exercise	□ Work
□ Sleep	□ Hobbies	□ Cooking	□ Bathing	□ Other

Have you ever had any imaging for this complaint? (MRI, CT, X-rays):____Date:_____
What treatments have you undergone in the past that has not fixed your complaint?

□ Medications	□Physical Therapy	□ Injections	□ Massage	□ Chiropractic
□ Acupuncture	□Personal Training	□ Homeopathy	□ Herbs	□ Exercise

Prior Chiropractic Experience: Have you been to a Chiropractor in the past? □ Yes □ No
If yes: Date of your last Adjustment: _____ How long were you treated? _____
Do you have a history of spine, disc or nervous system problems: ❑ Yes ❑ No If yes, explain:
_____

List ALL over the counter, prescription medications, herbs, nutritional supplements you are taking:

Medication/ Supplement	Dose and Frequency	Reason for Taking (for what symptoms)	Start Date	Prescribed By:

May we send your exam findings and our recommendations to your Pediatrician ? □ Yes □ No

Your Medical Doctor's Name and Phone#: _____

Privacy Authorization:

Our goal is to make your experience with us exceptional. Your signature below will verify that you have been given the option to review and understand our notice of privacy practices. You agree that we may contact you via email, phone, or mail in regard to your care and to keep you up to date on events taking place within the office. We will not share your information, we use Audio, video, and photos at functions, during training, in office, we use these in research studies, testimonials, and social media.

Assignment of Insurance Benefits:

We will verify your insurance before your report of findings with Dr. Black, and we will discuss any insurance coverage & expected contributions towards our recommendations for you. We will file directly to your insurance company for your care. All fees for today's exam, scans, and any x-rays will be due in full today, these fees will be discussed with you prior to services being performed today. The undersigned patient and or responsible party, in addition to continuing personal responsibility and consideration of treatment rendered, assigns to Ethos Regen, PLLC & Associates the following rights:

Release Information:

You are authorized to release information concerning my condition and treatment to my insurance company, or insurance adjuster, for purposes of processing/appealing my claim for benefits and payment of services rendered to me.
All payments for services will be made payable to: Ethos Regenerative Medical Group, PLLC
I hereby grant Ethos Regenerative Medical Group, PLLC the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance group, company representing payment for treatment, consultations and any and all health care rendered.

PRINT Insured Name: _____. Guardian Signature: _____ Date: _____