West Chester Chiropractic Center, Inc

Youth Application Form

For Patients 0-17

Welcome to our office! We specialize in assisting our patients to achieve their highest level of health through our spinal corrective programs along with other lifestyle and holistic recommendations. Our approach is very unique and advanced from other rehabilitation programs. This allows our patients to achieve far superior results compared to other systems.

Please fill out the following information completely so the doctor can get a thorough understanding of your health status. Please feel free to ask any questions if you need assistance.
We look forward to serving you!

Patient Name:_____

Patient Signature:_____

Parent Name:_____

Parent Signature:_____

Date:_____

Tell Us About The Patient

Name:_____ Age:_____ Gender: M F

Home Address:_____ Home: ( )_____

City, State, Zip:_____

Birth Date:_____ Social Security #:_____ Primary Physician:_____

Parent's Information

Parent's Name:_____ Parent's Phone #:_____

Can we leave a message on your: Cell Home Office With Spouse

Parent's Email Address:_____Parent's Social Security #:_____

Parent's Employer:_____ Work #:_____

How were you referred to this office?:_____

Purpose Of This Visit

Main Health Concern:_____

Other Health Concerns:_____

Is this problem related to an auto accident? Yes No If so, when:_____

Describe:_____

When did this condition begin?_____ Is it getting worse: Yes No

Please describe the pain and it's location:_____

When and how often do you (the patient) notice it?

_____

This condition is: Constant Comes and Goes Activity Related Dull Sharp

This complaint interferes with: Sleep Hobbies Sitting Standing Bending Lifting Sports

Is there anything that has relieved your symptoms? Yes No Describe:_____

Has this been experienced before? Yes No When?_____

Describe:_____

Who have you seen for this?_____ What did they recommend?_____

How did you (the patient) respond?_____

Patient's Experience With Chiropractic

Have you seen a Chiropractor before? Yes No Who?_____ When?_____

Reason for visit:_____

How did you respond?_____

Did your previous chiropractor take before and after x-rays? Yes No
(If x-rays were taken at a previous doctor's office, please bring them to your appointment if possible.)

Did they instruct you on postural exercises? Yes No

Health and Lifestyle

Do you exercise? Yes No How often? ____x per week Other:_____

Do you play sports? Yes No What sport? _____

Percent of Time: Sitting:_____ Standing:_____

Do you drink soda? Yes No How many cups/ day?_____

Are you on a special diet? _____

List all supplements: _____

List all medications: _____

Please list any surgeries:_____

Cervical Spine

Postural distortions from subluxations in your neck, as in Forward Head Syndrome, irritate nerves and other organs and can cause the following.

Check All That Apply: (A) Past (B) Present (C) Recurring

A	B	C		A	B	C		A	B	C	
☐	☐	☐	Neck Pain	☐	☐	☐	Dizziness	☐	☐	☐	Headaches
☐	☐	☐	Pain in your shoulders/ arms/hands	☐	☐	☐	Visual disturbances	☐	☐	☐	Recurrent colds/ flu
☐	☐	☐	Numbness/tingling in arms/hands	☐	☐	☐	Coldness in hands	☐	☐	☐	Allergies/ Hay fever
☐	☐	☐	Hearing disturbances	☐	☐	☐	Thyroid conditions	☐	☐	☐	Low energy/ fatigue
☐	☐	☐	Weakness in grip	☐	☐	☐	Sinusitis				

Explain: _____

Thoracic Spine (Upper Back)

Postural distortions from subluxations in the upper back can irritate the nerves to the heart and lungs and can cause the following:

Check All That Apply: (A) Past (B) Present (C) Recurring

A	B	C		A	B	C	
☐	☐	☐	Heart Palpitations	☐	☐	☐	Recurrent Lung Infections/Bronchitis
☐	☐	☐	Heart Murmurs	☐	☐	☐	Asthma/ Wheezing
☐	☐	☐	Increased Heart Rate	☐	☐	☐	Shortness of breath
☐	☐	☐	Decreased Heart Rate	☐	☐	☐	Pain on deep inspiration/ expiration

Thoracic Spine (Mid Back)

Postural distortions from subluxations in the mid back can irritate the nerves into your ribs, chest, upper digestive tract and organs and can cause the following:

Check All That Apply: (A) Past (B) Present (C) Recurring

A	B	C		A	B	C	
☐	☐	☐	Mid Back Pain	☐	☐	☐	Nausea
☐	☐	☐	Chest Pain	☐	☐	☐	Ulcers/ Gastritis
☐	☐	☐	Indigestion/ Heartburn	☐	☐	☐	Hypoglycemia
☐	☐	☐	Reflux	☐	☐	☐	Tired after eating or irritable when you haven't eaten for awhile

Lumbar Spine (Low Back)

Postural distortions from subluxations in the low back can irritate nerves into your legs, feet and pelvic organs and cause the following:

Check All That Apply: (A) Past (B) Present (C) Recurring

A	B	C		A	B	C	
☐	☐	☐	Pain Into Your Hips/Legs/Feet	☐	☐	☐	Weakness/ Injuries In Your Hips/Knees/Ankles
☐	☐	☐	Bladder Infections	☐	☐	☐	Numbness/Tingling In Your Legs/Feet
☐	☐	☐	Coldness In Your Legs/Feet	☐	☐	☐	Frequent/Difficulty Urinating
☐	☐	☐	Constipation/ Diarrhea	☐	☐	☐	Muscle Cramps In Your Legs/ Feet
☐	☐	☐	Low Back Pain	☐	☐	☐	Menstrual Irregularities/ Cramps (females)

Neck Disability Index

Please Read carefully! This questionnaire has been designed to enable us to understand how your **neck pain** has affected your ability to manage everyday life. Please answer every section, and mark the box that most accurately describes you're your problem right

Pain Intensity
A. I have no pain at the moment.
B. The pain is very mild at the moment
C. The pain is moderate at the moment
D. The pain is fairly severe at the moment
E. The pain is very severe at the moment
F. The pain is the worst imaginable at the moment

Personal Care (washing, dressing, etc.)
A. I can look after myself without causing extra pain
B. I can look after myself normally but it causes extra pain
C. It is painful to look after myself and I am slow and careful
D. I need some help but manage most of my personal care
E. I need help everyday in most aspects of self care
F. I do not get dressed, wash with difficulty and stay in bed

Lifting
A. I can lift heavy weights without extra pain
B. I can lift heavy weights but it gives extra pain
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned. E.g. on a table
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights
F. I cannot lift or carry anything at all

Reading
A. I can read as much as I want with no pain to my neck
B. I can read as much as I want with slight pain in my neck
C. I can read as much as I want with moderate pain in my neck
D. I cannot read as much as I want because of moderate pain in my neck
E. I can hardly read at all because of severe pain in my neck
F. I cannot read at all because of severe pain in my neck

Headaches
A. I have no headaches at all
B. I have slight headaches which come infrequently
C. I have moderate headaches which come infrequently
D. I have moderate headaches which come frequently
E. I have severe headaches which come frequently
F. I have headaches almost all the time

Concentration
A. I can concentrate fully when I want to with no difficulty
B. I can concentrate fully when I want to with slight difficulty
C. I have a fair degree of difficulty in concentrating
D. I have a great deal of difficulty in concentrating
E. I cannot concentrate at all

Work
A. I can do as much work as I want to
B. I can only do my usual work, but no more
C. I can do most of my usual work, but no more
D. I cannot do my usual work
E. I can hardly do any work at all
F. I cannot do any work at all

Driving
A. I can drive without any neck pain
B. I can drive as long as I want with slight pain in my neck
C. I can drive as long as I want with moderate pain in my neck
D. I cannot drive as long as I want because of moderate pain in my neck
E. I can hardly drive at all because of severe pain in my neck
F. I cannot drive my car at all

Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hr sleepless)
C. My sleep is mildly disturbed (1-2 hrs sleepless)
D. My sleep is moderately disturbed (2-3 hrs sleepless)
E. My sleep is greatly disturbed (3-5 hrs sleepless)
F. My sleep is completely disturbed (5-7 hrs sleepless)

Recreation
A. I am able to engage in all my recreation activities with no neck pain at all
B. I am able to engage in all my recreation activities with some pain in my neck
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
D. I can hardly do any recreation activities because of pain my neck
E. I cannot do any recreation activities at all

Other Comments:

_____

Patient Name:_____

Patient's Signature:_____ Date:_____

Back Disability Index

Please Read carefully! This questionnaire has been designed to enable us to understand how your **back pain** has affected your ability to manage everyday life. Please answer every section, and mark the box that most accurately describes your problem right now.

Pain Intensity
A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain comes and goes and is severe
F. The pain is severe and does not vary much

Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain
C. Washing and dressing increases the pain, but I manage not to change my way of doing it
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it
E. Because of the pain, I am unable to do some washing and dressing without help
F. Because of the pain, I am unable to do any washing or dressing without help

Lifting
A. I can lift heavy weights without extra pain
B. I can lift heavy weights but it gives me extra pain
C. Pain prevents me from lifting heavy weights off the floor
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
F. I can only lift very light weights, at the most

Walking
A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than 1 mile
C. Pain prevents me from walking more than 1/2 mile
D. Pain prevents me from walking more than 1/4 mile
E. I can only walk using a stick or crutches
F. I am in bed most of the time and have to crawl to the toilet

Sitting
A. I can sit in any chair as long as I like without pain
B. I can only sit in my favorite chair as long as I like
C. Pain prevents me from sitting more than 1 hour
D. Pain prevents me from sitting more than 1/2 hour
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all

Standing
A. I can stand as long as I want without pain
B. I have some pain while standing but it does not increase with time
C. I cannot stand for longer than 1 hour without increasing pain
D. I cannot stand for longer than 1/2 hour without Increasing pain
E. I cannot stand for longer than 10 minutes without increasing pain
F. Pain prevents me from standing at all

Sleeping
A. I get no pain in bed
B. I get pain in bed, but it doesn't prevent me from sleeping well
C. Because of pain, my normal night's sleep is reduced by less than one-quarter
D. Because of pain, my normal night's sleep is reduced by less than one-half
E. Because of pain, my normal night's sleep is reduced by less than three-quarters
F. Pain prevents me from sleeping at all

Social Life
A. My social life is normal and gives me no pain
B. My social life is normal, but increases the degree of my pain
C. Pain has no significant effect on my social life apart from limiting my more energetic interests- eg dancing
D. Pain has restricted my social life and I do not go out very often
E. Pain has restricted my social life to my home
F. I have hardly any social life because of the pain

Traveling
A. I get no pain while traveling
B. I get some pain while traveling but none of my usual forms of travel make it any worse
C. I get extra pain while traveling but it does not compel me to seek alternate forms of travel
D. I get extra pain while traveling which compels me to seek alternative forms of travel
E. Pain restricts all forms of travel
F. Pain prevents all forms of travel except that done laying down

Changing Degree of Pain
A. My pain is rapidly getting better
B. My pain fluctuates, but overall is definitely getting better
C. My pain seems to be getting better, but improvement is slow at present
D. My pain is neither getting better nor worse
E. My pain is gradually worsening
F. My pain is rapidly worsening

Patient Name:_____

Patient's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

Authorization For Payment on Child's Account

West Chester Chiropractic Center requires a credit card be on file for all patients. Unless we have agreed otherwise, payment is due in full for all services rendered on the day that services are provided.

How does the pre-authorized payment procedure work?
This is a convenient payment method in which you authorize us to bill your credit card for outstanding balances on your account. You will be notified of the balance due and given the opportunity to pay in full with either cash, check or credit card. If we are unable to contact you or we do not receive full payment within the 7 days after notification we will automatically charge your credit card. This is not to be used as a daily or weekly method of payment as services are rendered. If we are billing your insurance company and do not receive payment within 30 days you will be notified so you can contact them. If they do not pay within 15 days after the initial 30 days, or if any part of your care is denied, you are responsible for the outstanding balance in full.

☐ **Daily Charge Option for Children Who Attend Without Parents (optional)**
I authorize West Chester Chiropractic Center, Inc. to debit the credit card listed below for services my child has incurred during their visits. This authorization will remain in full force until I give notice to discontinue billing this account. _____(parent initials).

Would you like a monthly statement of your child's charges? Yes No

Credit Card Information (Required for all patients)

Cardholder Name:_____

Credit Card Account Number:_____

Expiration Date:_____ Security # on back of card:_____

Type of Card (circle one): Visa Mastercard Discover

Authorization:
I authorize West Chester Chiropractic Center to keep my signature on file and to charge my Visa/ Mastercard/ Discover card for any outstanding balance on my account as stated above. I understand that this information is correct to the best of my knowledge and will inform West Chester Chiropractic Center, Inc. of any changes.

Parent Signature:_____ Date:_____

Massage Authorization

Patients may request massages and the doctor may recommend that a patient receive them. We do require that all patients read the below information and sign the authorization form.

As a courtesy to our patients, and to ensure you receive your full allotted time, please arrive five minutes prior to your scheduled massage appointment. If you need to cancel your appointment, please call 24 hours in advance in order to prevent being charged in full for your missed appointment. Thank you for your cooperation and understanding.

I _____agree to the above policy._____

Sign Name Date