Welcome to our office! We are sure that you will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with today's examination procedures, which will determine how we can help you, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs that these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we get from you is important. We use your health history, x-rays, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time to the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Justin & Woodbury Spine Staff ☺

CHILD MEMBER HEALTH RECORD

ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	
HEIGHT:	WEIGHT:

ABOUT THE PARENT

PARENT'S NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
NUMBER OF CHILDREN:	
EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	ZIP CODE:
EMPLOYER'S CITY:	
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD?

___YES ___NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:

___DPT ___MMR ___CHICKEN POX ___HEPATITIS ___OTHER

DESCRIBE ANY AND ALL REACTIONS TO THE VACCINE(S):

WOODBURY SPINE WELLNESS CENTER
A COMMUNITY INSPIRED BY WELLNESS

8147 Globe Drive, Suite 100
WOODBURY, MN 55125
651-731-0505 (OFFICE)
651-731-0500 (FAX)

CHILD'S CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

DID YOU SEE OR HEAR OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):
___NEWSPAPER ___SIGN ___YELLOW PAGES
___MAILING ___COMMUNITY EVENT ___OTHER_____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ___YES ___NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR OF CHIROPRACTIC'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO :
___SPORTS ___AUTO ___FALL
___HOME INJURY ___OTHER
PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
___GOTTEN WORSE ___STAYED CONSTANT
___COME AND GONE

DOES THIS CONDITION INTERFERE WITH :
___SLEEP ___DAILY ROUTINE ___OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
___YES ___NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ___YES ___NO

DOCTOR(S) NAME(S):

TYPES OF TREATMENTS:

RESULTS:

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:
___DRUGS/MEDICATIONS ___TOBACCO/ALCOHOL
IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:
___LABOR WAS CHEMICALLY INDUCED ___FORCEPS/VACCUM
___PREMATURE DELIVERY ___C-SECTION DELIVERY
___LABOR WAS DOCTOR ASSISTED
___DOCTOR PULLED OR TWISTED THE BABY

PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT?

DO/DID YOU NURSE YOUR BABY? ___YES ___NO
DO/DID YOU EXPERIENCE FEEDING PROBLEMS? ___YES ___NO
DOES/DID YOUR BABY HAVE COLIC? ___YES ___NO
VACCINATIONS? ___YES ___NO

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

___ALLERGIES	___CONSTIPATION	___IRRITABLILITY
___ASTHMA	___DIGESTIVE PROBLEMS	___SKIN PROBLEMS
___ATTENTION PROBLEMS	___EAR PROBLEMS	___SLEEP DISORDERS
___BED WETTING	___HEADACHES	___VISION PROBLEMS
___BREATHING PROBLEMS	___FREQUENT COLDS	___TUBES IN THE EARS
___COLIC	___HYPERACTIVITY	___OTHER:

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?
___YES ___NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED?
___YES ___NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SEVERE FALL?
___YES ___NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?
___YES ___NO PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE?
___YES ___NO PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY?
___YES ___NO PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ___YES ___NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS? ___YES ___NO
PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES, OR EXHIBITS ROCKING BEHAVIOR? ___YES ___NO
PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ___YES ___NO	THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ___YES ___NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ___YES ___NO	IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ___YES ___NO

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assitant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered by my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Nye will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Woodbury Spine Wellness Center, LLC directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

NAME OF CHILD:_____ BIRTHDATE:_____

PARENT OR GUARDIAN AUTHORIZING CARE'S SIGNATURE:_____ DATE:_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.

PATIENT'S NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

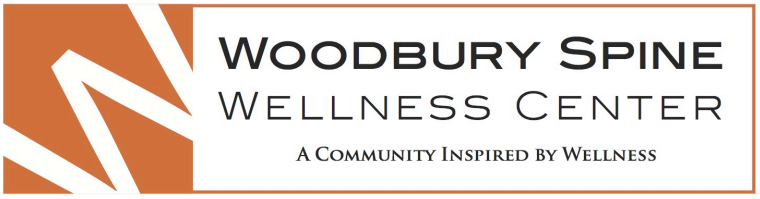
An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services 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 to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS' SIGNATURE:	DATE:



Date: _____

I _____ give permission to Woodbury Spine Wellness Center and the doctors who own the facility, to use my photographs, videos and any handwritten/emailed testimonials from me for advertising purposes both internal and external. This would include but is not limited to: newsletters, print ads, websites, in office use, and any other promotional items for the office.

Should I request to have my photos, videos or written testimonials removed, I will inform the doctors in writing.