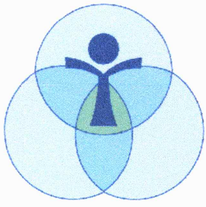


McCann Family Chiropractic
11605 State Ave, Suite 111
Marysville, WA 98271
Ph. (360) 657-7183
fax (360) 657-7188
email: frontdesk@mfcwellness.com
website: www.mfcwellness.com

Child's Information

Child's Name ______________________________________ Date ______________

Parent(s) Names

____

Siblings' Names and Ages

____

Address ____________________________ City/Town ____________ Zip Code __________

Parents' E-mail Address

____

Date of Birth _____m/_____d/_____y/ Gender: ◯ Male ◯ Female

Home Ph _______________ Business Ph _______________ Mobile Ph __________________

Best time/ place to contact you? ____

Whom may we thank for referring your child to this office? ______________________________

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: ____________________________________

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: ______________________

Name & Address of Obstetrician/ Midwife:

____

Name & Address of Primary Health Care Provider:

____

Date of last visit _________________ Purpose of visit ________________________________

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: ___________ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy____

Any ultrasounds or other radiation? ◯ Yes ◯ No

How many and for what reasons? ____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _______________________________

Drink Alcohol? ◯ Yes ◯ No How much? _______________________________

Prescription Medications? ◯ Yes ◯ No How much? _______________________________

Recreational Drugs? ◯ Yes ◯ No How much? _______________________________

Fall ill during pregnancy? ◯ Yes ◯ No please explain _______________________________

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: ____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_______________________

LABOR

Was labor induced? ○ Yes ○ No

Duration of labor? ________________________________

Duration of active (pushing stage) labor?___________________________

Did mother receive medications? ○ Yes ○ No

If yes, which: ____

BIRTH

Type of birth? ○ Vaginal: Cephalic (head first) ○ Breech (feet first) ○ C-Section

Location of birth? ○ Home ○ Hospital ○ Birthing center

Birth Assistants? ○ Midwife ○ Doula ○ Obstetrician

Was there any assistance needed during birth?

○ Forceps ○ Caesarean ○ Vacuum Extraction ○ Induction ○ Assisted Traction/Head Turning

Was delivery considered normal? ○ Yes ○ No

Were there complications during birth? ○ Yes ○ No

Please explain:

____

Was there any evidence of birth trauma to the infant? Check all that apply:

○ Bruising ○ Odd shaped head

○ Stuck in birth canal ○ Fast or excessively long birth

○ Respiratory depression ○ Cord around neck

Was your child subjected to any of the following? Check all that apply:

○ Silver nitrate drops in eyes ○ Incubation How long? _____________

○ Vitamin K shot ○ Separation from you How long? _____________

○ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____________________

APGAR score at birth? ______________ APGAR score at 5 minutes? __________________________

Birth Weight? _____________________ Birth Length? _____________________________________

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No ______________________

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No ______________________

Did your baby spit up after feeding? ◯ Yes ◯ No ______________________

Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No ______________________

Does child ever bang his/her head repeatedly? ◯ Yes ◯ No ______________________

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No ______________________

Any hospitalizations or surgeries? ◯ Yes ◯ No ______________________

Please list all surgeries your child has had:

1. Type ______________________ When __________ Doctor ______________

2. Type ______________________ When __________ Doctor ______________

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type______________________ When______________ Hospitalized? ◯ Yes ◯ No

2. Type______________________ When______________ Hospitalized? ◯ Yes ◯ No

3. Type______________________ When______________ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?__________ Where?__________

What area of your child's body:______________________________________

Does your child play sports? ◯ Yes ◯ No ______________________

If yes, hours per week? __________ Age child began? ______________________

Is school backpack used? ◯ Yes ◯ No Weight of backpack? ____________________kg/lbs

Approximate hours spent at play per week? ______________________________

Average time spent at computer/TV/video games per week? _______ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No ______________________

Does your child have trouble reading the board? ◯ Yes ◯ No ______________________

Does your child have difficulty with coordination? ◯ Yes ◯ No ______________________

CHEMICAL STRESS

Was/is child breast-fed? ○ Yes ○ No For how long? ______________________

At what age was:

Formula introduced? ______________________ Brand? ______________________

Cow's milk introduced? ______________________

Solid food? ______________________

Food/juice intolerance? ○ Yes ○ No ______________________

Does your child have food allergies? ○ Yes ○ No ______________________

What is your child's favorite food? ______________________

What does your child regularly drink? ______________________

The type of diet your child usually follows is classified as: ______________________

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs	_____	Fasting	_____	Fruit	_____		
Fish	_____	Diet Food	_____	Organic Foods	_____		
Coffee	_____	Beef	_____	Weight Control Diet	_____	Raw Vegetables	_____
Soft Drink	_____	Poultry	_____	Artificial Sweetener	_____	Whole Grains	_____
Fried Foods	_____	Seafood	_____	Cooked vegetables	_____		
Refined Sugar	_____	Dairy	_____	Canned/Frozen vegetable	_____		

Does your child have a bowel movement every day? ○ Yes ○ No ______________________

Does your child have regular or occasional skin rashes? ○ Yes ○ No ______________________

What vaccinations were given and at what age?

____

____

Were there any negative reactions? ○ Yes ○ No ______________________

Was there any:

- ◯ Fever
- ◯ Inconsolable crying
- ◯ Irritability
- ◯ Arching of body
- ◯ Bowel disturbances
- ◯ Feeding disturbances
- ◯ Drowsiness
- ◯ Other: ____________________

History of antibiotics? ◯ Yes ◯ No

If so, how many courses of antibiotics has your child received in their lifetime? ____________________

Reason and length of last course of antibiotics? ____________________

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name ____________________ Dosage ________ For what? ____________________

Name ____________________ Dosage ________ For what? ____________________

Name ____________________ Dosage ________ For what? ____________________

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name ____________________ For what? ____________________

Name ____________________ For what? ____________________

Are there pets in the home? ◯ Yes ◯ No ____________________

Are there any smokers at home? ◯ Yes ◯ No ____________________

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding? ◯ Yes ◯ No ____________________

Did mother and baby have difficulty bonding? ◯ Yes ◯ No ____________________

Did mother experience any post-partum depression? ◯ Yes ◯ No ____________________

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No ____________________

Do you consider their sleeping pattern normal? ◯ Yes ◯ No ____________________

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours ____________________

Behavior problems? ◯ Yes ◯ No ____________________

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend day care? ◯ Yes ◯ No From what age? ____________________

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: ____________________

At what age did your child:

Respond to sound?	________	Sit alone?	________
Follow an object?	________	Teethe?	________
Hold head up?	________	Crawl?	________
Vocalize?	________	Walk?	________

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

____

On father's side:

____

Do any siblings have any health concerns? ◯ Yes ◯ No

If yes, please describe: ____________________

Consent to assess and adjust a minor:

I, ____________________, being the parent or legal guardian of

(PARENT/GUARDIAN NAME)

____________________, hereby grant permission for my child to receive a

chiropractic assessment and chiropractic care.

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 towards the same objective.

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

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.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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.

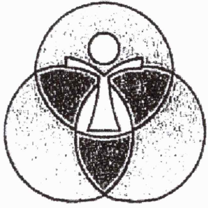
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.
However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we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

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)*



X-ray Consent and Statement of Non-pregnancy

X-ray studies are one way of looking at the structure of the human frame. Doctors of Chiropractic utilize X-ray analysis as a valuable tool to see if the body is properly balanced and if vertebrae and other skeletal structures are in proper alignment. This helps us determine the structural integrity of your skeletal system.

Long-term spinal nerve stress (vertebral subluxation) may cause an inflammatory condition of the bone and related structures and may result in premature aging called spinal degeneration (also known as osteo-arthritis). An X-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For this reason, we limit X-ray exposure as much as possible and we only perform x-ray studies when it is clinically necessary.

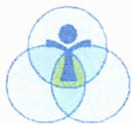
I hereby consent to any necessary chiropractic X-ray studies (that the doctor will inform me of during the examination). This will allow the doctor to fully determine the condition of my spine.

Signature:_______________________________ Date:_____________

For Women Only:

Due to the chance of adverse effects on rapidly dividing cells and body tissue, X-rays have been shown to have negative effects on unborn children. Therefore, X-ray studies on pregnant women should only be done in an emergency. In signing below, I state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Signature:_______________________________ Date:_____________



McCann Family Chiropractic

11605 State Avenue, Suite 111, Marysville, WA 98271
360-657-7183

McCann Family Chiropractic Office Financial Policy

Welcome to McCann Family Chiropractic. Our goal is to provide you with excellent service, including transparent financial policies and procedures. Please read this policy carefully and do not hesitate to ask a member of our team if you have any questions.

Primary Contact: Billing Coordinator, Stephanie Lofton, backdesk@mfcwellness.com

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Like all types of care, coverage for chiropractic and massage services varies from insurer to insurer and plan to plan. Our office will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

It is your responsibility to understand your benefit plan. You are responsible for any and all deductibles, co-payments, and co-insurances. Co-payments and co-insurance payments are due at the time of service. Deductible amounts are due immediately upon receipt of an Explanation of Benefits. You may keep a credit card on file for payment of services. Your credit card information will always be stored securely and this will help to ensure your account is current and not subject to late fees.

Additionally, not all services are covered by insurance. We will make every attempt to inform you of non-covered services so that you can make an informed decision; however, **you are ultimately responsible for all services rendered**.

Please inform us of any insurance changes as soon as you are aware of them, including auto accidents or work injuries.

Time Of Service Discount

If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. If you do not have insurance or we do not participate in your insurance plan, you may be entitled to a 20% time of service discount ("TOSD"). This discount reflects a reduction in our costs for not having to bill you or your insurance company. In order to be eligible to receive this discount, you **MUST** pay at the time of service and no balance may be outstanding on your account.

Wellness care and supplements are not covered by insurance and are not billed to third parties. Therefore, no TOSD applies.

Care Plan

You may be offered an estimated care plan with a monthly payment option. Care plans require a credit or debit card to be kept on file for monthly auto-payment. Further details regarding care plans will be discussed if this option applies to you.

Cancellation Policy

Please call our office to cancel your appointment by 8 AM the business day prior to your appointment. (Business day is Monday to Friday, regardless of whether the office is open for chiropractic or massage appointments over the weekend). There is no cancellation fee for chiropractic appointments, however, we greatly appreciate the courtesy of your notice.

Massage cancellations that do not adhere to the above policy are billed at $50. This fee is not billable to any insurance company, including work or auto injury, and is your direct responsibility.

Past Due Accounts

Any account with a balance of greater than 30 days may be charged a service fee of 12% per year, compounded monthly. Any account where no payment has been received for over 60 days, and has not made payment arrangements with the Billing Coordinator may be sent to a third party collections agency. Any additional collection fees will be the responsibility of the patient.

NSF checks or rejected credit card payment will be charged a service fee of $25 per occurrence.

Patient Name(s): ____

______________________________ ______________
Responsible Party's Name Relationship

______________________________ ______________
Responsible Party's Signature Date

PATIENT ACKNOWLEDGMENT

I acknowledge I have received and read the Notice of Privacy Practices.

_______________________________________ ____________________

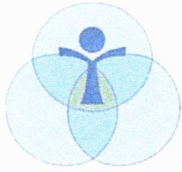
Name Date

____

Signature

____

Relationship to Patient (if patient is a minor or not able to sign)



McCann Family Chiropractic

11605 State Avenue, Suite 111
Marysville, WA 98271

360-657-7183 p
360-657-7188 f

Date:______________________

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, or other communications.

I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_________________________________ _________________________________

Patient name

Patient Signature
(Parent/Guardian if patient under 18 years of age)

Text / Email (circle one and fill in space below)

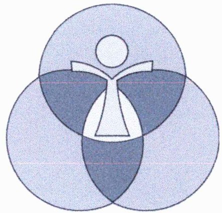
Cell number: ____________________ Email: ________________________________

If Text is preferred, cell phone provider: ___________________________

Receive reminder how soon before appointment? (circle one)

1 hour
4 hours
1 day

Rev. June 14, 2018



Consent to Evaluate and Adjust a Minor

I, ______________________________________, being the parent or legal guardian of

____ have read and fully understand the

terms of acceptance and hereby grant permission for my child to receive chiropractic

Care/ massage therapy, consisting of evaluation and adjustments (if necessary) and massage while I am not present.

Signature: __________________________________ Date: ___________________