Address:
2149 E. Garvey Ave. N.
Suite # A-5
West Covina, CA 91791

CHIRO WELLNESS

Individualized Healthcare

It's all about the uniqueness of your child

Phone: 626-233-6366
Email: chirowellnesswc@gmail.com

PATIENT INFORMATION

Patient Name: _____ Date: _____
DOB: _____ Age: _____ Sex: ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Office #: _____ Cell #: _____
Where do you prefer to receive calls? ___Home ___Office ___Cell ___No preference

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____

Relationship to Patient _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

DOB: _____

Insurance Company: _____ Phone #: _____

Policy ID#: _____ Group#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much is your copay? _____ Maximum Annual Benefit? _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
Name of Insurance Carrier

To Dr. Helmer Velez all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Parent, Guardian or Personal Representative Relationship to patient

Present Health Challenge(s):

For what health challenge(s) is your child here for?

_____

What do you feel is the cause of your child's problem?

_____

When did you first notice this sign of body dysfunction?

_____

Is this dysfunction getting progressively worse? ___Yes ___No
If yes, why do you think so?

_____
_____

What are the most significant measures you have taken to date to improve your child's present health challenge? Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

_____
_____
_____
_____
__

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

_____
_____
_____
_____
__

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____
_____
_____
_____
_

____ Allergies	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/sore Throat	____Tonsillitis	____Laryngitis
____Colic	____Reflux/spitting up	____U-tract infections	____Poor appetite
____Poor digestion/ (constipation/diarrhea)	____Thrush mouth/ Chronic diaper rash	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD
____Irregular sleep Patterns	____Night terrors	_____Bed wetting	____Headache
____Anxiety	____Mood swings	____Bruising	

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?
Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

_____
_____
_____
_____
_____

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? ____ Yes ____No
If yes, for what reason and for how long? _____
_____
_____
_____
_____

Has your child ever been hospitalized? ____ Yes ____No
If yes, why and when? (Please list in chronological order) _____
_____
_____
_____
_____

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

_____
_____
_____
_____

Please check any of the following sports activities that your child is engaged in.

____ Football	____ Lacrosse	____ Soccer	____Track/Field
____ Bowling	____ Tennis	____ Hockey	____ Volleyball
____Baseball/Softball	____ Skateboarding	____ Snowboarding	____ Skiing
____ Gymnastics/Trampoline	____ BMX/Motorcross	____ Swimming	____Golfing

Has your child ever been injured while playing sports? ____ Yes ____No
If yes, what type of injury(s) occurred? _____
_____
_____
_____
_____

Recent research reveals that 30% of American children are obese with more than 50% of all US children overweight.
On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5
Non-Complex Carbohydrates **Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy**	**Complex Carbohydrates** Fruits & Vegetables	**Protein** Nuts, Seeds, Meats, Eggs	**Fats** Dairy Products

Please list the (3) most common foods eaten by your child each day.
_____

How many times per month does your child eat fast food? _____
What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ___ Yes ___No
If yes, what type of artificial sweeteners does your child use? _____

Was your child breast fed? ___Yes ___No If yes, for how long? _____

Was your child formula fed? ___Yes ___No If yes, what type and for how long? _____

At what age did you introduce solid foods into your child's diet? _____ What type(s)? _____

Has your child exhibited any tolerance and/or allergy to any specific food? ___Yes ___No
If yes, please list all foods._____
_____

Has your child been tested for allergies? ___Yes ___No

If yes, how were the tests performed? _____

What were the results? _____
_____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)
_____
_____
_____

Has your child received treatment for any type allergy? ___Yes ___No
If yes, what type f treatment? _____
_____
_____
_____

CHIRO WELLNESS

Minor / Child Consent Form

I am the parent, guardian, or personal representative of _____
(Please print name of minor / child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, which are deemed advisable by the doctor.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative Date

❑ I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. ***(This applies to children 14 years of age or older.)***

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Witness Signature Date

CHIRO WELLNESS

Informed Consent To Chiropractic Care

We encourage and support a shared decision making process between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

● **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

● **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE CHIRO WELLNESS TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS _____ DAY OF _____, 2022.

_____ _____

Patient Signature **Doctor Signature**

Parental Consent for Minor Patient

Patient Name:_____ Patient Age: _____ DOB: _____

Printed name of person legally authorized to sign for patient
Name: _____ Relationship to patient: _____

Signature: _____