



Schmidt Chiropractic Center  
**PEDIATRIC CASE HISTORY**

Delivery/Birth History: \_\_\_\_\_

At What Age Did the Child:

Respond to Sound \_\_\_\_\_ Follow An Object With His/Her Eyes \_\_\_\_\_ Hold Head Up \_\_\_\_\_

Sit Alone \_\_\_\_\_ Crawl \_\_\_\_\_ Stand \_\_\_\_\_ Walk Alone \_\_\_\_\_

At What Age, If Ever, Did This Child Suffer From The Following Childhood Diseases?

Chickenpox \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_

Rubeola \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

Has the Child Ever Suffered From:

- |                                               |                                              |                                              |                                              |
|-----------------------------------------------|----------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Neck Problems       | <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Stomach Aches       | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Reflux              | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches     | <input type="checkbox"/> Backaches           | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Allergies to: _____ |
| <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Allergies to: _____ |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Allergies to: _____ |
| <input type="checkbox"/> Colds/Flu            | <input type="checkbox"/> Walking Trouble     | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Colic                | <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Other _____         |

Has This Child Ever Suffered The Following Spinal Traumas?

- |                                                   |                                                 |                                                        |
|---------------------------------------------------|-------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Fall in Baby Walker      | <input type="checkbox"/> Fall From Bed or Couch | <input type="checkbox"/> Fall Off Skateboard or Skates |
| <input type="checkbox"/> Fall From Crib           | <input type="checkbox"/> Fall Off Swing         | <input type="checkbox"/> Fall Off Bicycle              |
| <input type="checkbox"/> Fall From Highchair      | <input type="checkbox"/> Fall Off Slide         | <input type="checkbox"/> Fall Down Stairs              |
| <input type="checkbox"/> Fall From Changing Table | <input type="checkbox"/> Fall Off Monkey Bars   | <input type="checkbox"/> Other _____                   |

Has This Child Ever Sustained An Injury Playing Organized Sports? \_\_\_\_\_ If Yes, Please Explain: \_\_\_\_\_

Has This Child Ever Sustained Injuries In An Auto Accident? \_\_\_\_\_ If Yes, Please Explain: \_\_\_\_\_

Present History \_\_\_\_\_

Hospitalization/Surgeries \_\_\_\_\_

Medications \_\_\_\_\_

Accidents \_\_\_\_\_

Family History \_\_\_\_\_

**PEDIATRIC PATIENT INTRODUCTION**

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Address \_\_\_\_\_ Father's Name \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Mother's Work Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_ Mother's Email \_\_\_\_\_  
Father's Work Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_ Father's Email \_\_\_\_\_  
Referred by \_\_\_\_\_

Child's Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Number of Siblings \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Current Weight \_\_\_\_\_ Current Length \_\_\_\_\_

Third Trimester Presentation: (check box)       Vertex       Breech       Transverse       Face/Brow  
Type of Birth: (check box)       Normal Vaginal       Forceps       Cesarean       Suction Cap or Vacuum  
Location: (check box)       Home       Birthing Center       Hospital  
Problems During Pregnancy \_\_\_\_\_  
Problems During Labor/Delivery \_\_\_\_\_

Apgar Scores: \_\_\_\_\_ Was There Presence at Birth of: (check box)       Jaundice (Yellow)       Cyanosis (Blue)

Congenital Anomalies/Defects?       Yes       No      If Yes, Please Explain \_\_\_\_\_

Infant Feeding:       Breast       Bottle      If Bottle, Which Formula? \_\_\_\_\_

Number of Hours Sleeping Per Night: \_\_\_\_\_ Quality of Sleep:       Good       Fair       Poor

Obstetrician/Midwife \_\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Purpose \_\_\_\_\_

Immunization \_\_\_\_\_

Number of Doses of Antibiotics Your Child Has Taken: During Past Six Months \_\_\_\_\_ During His/Her Lifetime \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Purpose \_\_\_\_\_

Has Your Child Ever Been Treated On An Emergency Basis?       Yes       No      If Yes, Please Explain \_\_\_\_\_

Purpose Of This Appointment \_\_\_\_\_

\*\*\*\*\*

**AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize Schmidt Chiropractic Center and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE: \_\_\_\_\_

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-Rays remain the property of this office.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

# Schmidt Chiropractic Center

320 E Hill St, PO Box 215  
Norwood Young America, MN 55368

## PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

**To the patient:** Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

**The nature of chiropractic adjustment:** The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click”, much as you have experienced when you “crack” your own knuckles. You may also feel a sense of movement.

**Examination and Treatment:** In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Orthopedic testing
- Range of motion testing
- Basic neurological exam
- Muscle strength testing
- Ultrasound
- Radiographic studies
- Rehabilitation/core strengthening
- Nutritional therapy
- Mechanical traction/flexion distraction
- Other \_\_\_\_\_

We will explain these procedures to you and answer any questions you have about them.

**The material risks inherent in chiropractic adjustment:** Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

### **The probability of risks occurring:**

**Soreness:** It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

**Fracture:** Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.

**Ruptured/Herniated Disc:** There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

**TIA/Stroke:** According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.

**Other complications:** These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

**The availability of other treatment options:** Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are also risks and benefits with each one of those options and you may wish to discuss these with your primary medical physician.

**The risks and dangers associated with remaining untreated:** Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**Notices of Privacy Practices:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

**Consent to Release of Information:**

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission to my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**PATIENT CONSENT FOR CHIROPRACTIC TREATMENT**

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: \_\_\_\_\_

I, \_\_\_\_\_, have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. **BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.** I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

I also grant permission to communicate my personal health information to others involved in my care for the purpose of treatment, results of tests and medical care at the following numbers.

Please specify your contact preference:

\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_ Cell phone: \_\_\_\_\_ Text: Yes or No  
\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Date Signature of patient or authorized person Authority to act on behalf of patient  
(Proof Required)



# Schmidt Chiropractic Center

320 E Hill St, PO Box 215 - Norwood Young America, MN 55368

[www.schmidtchiro.net](http://www.schmidtchiro.net) P: (952)467-2505 F: (952)467-9104

Dr. Julie Schmidt, DC & Dr. Nick Heckmann, DC GTS



## Financial Policy

### Participating Health Insurance

This clinic is a participating provider with the following insurances (these are subject to change at any time, and may include other healthcare plans):

- Blue Cross Blue Shield of Minnesota
- Preferred One Products & Select Care/Laborcare
- Medica, Principal Financial Group, United Health Care, Great-West Healthcare (Including Senior Plans)
- HealthPartners, Ucare, Cigna Health Care, Patient Choice (Including Senior Plans)

It is the responsibility of the patient to verify insurance coverage for chiropractic care. Benefits quoted are a general outline and are not a guarantee of payment. As a provider, the clinic cannot hold a patient responsible for any usual and customary provider reductions. Depending upon your plan, you may be responsible for a percentage, copay and or deductible at each visit. Services that are not covered by your healthcare plan's chiropractic benefits, and are not eligible for reimbursement, are your financial responsibility. Copays are due at time of service. If patient account is 90 days delinquent, the account will be turned over to a credit agency.

I choose to have the clinic submit my chiropractic treatments to my health insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

### Time Of Service Discount- Cash Rate

Patients without medical insurance, or those who have insurance and choose not to utilize their insurance benefits, are required to pay for their chiropractic treatment the same day that treatment was received at this clinic. By paying same day, you will be eligible for a **\*Time of Service\*** discounted rate of \$45.00 per treatment. By law, our clinic is also required to administer an initial exam. The cash rate for this one time initial exam service is \$100.00. You may also be responsible for services including, but not limited to: soft tissue massage prior to treatment and the spinal/extraspinal adjustments. Time of Service cash rates do not apply toward your annual out-of-pocket spending limits or yearly deductible. Cash, checks, all major credit cards or HSA/Flex spending cards are all forms of cash payments. If patient account is 90 days delinquent, account will be turned over to a credit agency.

**Please note: Time of Service discounted rate fees will not be submitted to any insurance.**

I choose to pay the **\*Time of Service Rate\*** of \$45.00 for my chiropractic treatments.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name