Dr. Jaylene Bair | Dr. Chris Hopkins
953 N. Harrison Ave, Cary, NC 27513 • (P) 919-234-0505 • (F) 919-694-1155
harmonychironc.com • info@liveinharmonync.com

OFFICE USE ONLY
ID #_____
Date: / /

Adult Pregnancy Intake Paperwork

HELLO AND WELCOME TO HARMONY!

Who may we thank for referring you / how did you hear about us? _____

Have you served in the military? ❑ No ❑ Yes

Please fill out the following information completely and to the best of your ability.
Sign the bottom of each page please.

Personal Information

First Name: _____ Last Name: _____ DOB: ___/___/___ Age: _____

Preferred name: _____ SSN: ___-___-_____ Height: ___ft___in Current Weight: _____lbs

Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Street Address: _____ Apt.Unit#: _____ City/State/Zip: _____

Cell Phone: _____ Occupation: _____ Gender: ❑ M ❑ F

Name(s)+Age(s) of Children: _____

Name of Spouse: _____

Hobbies: _____

Who is your primary care physician? _____ Date of last visit: ___/___/___

Reason for you last doctor visit: _____

Are you receiving care from any other health professionals? ❑ No ❑ Yes (if yes please list them by name and specialty)

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Please note any significant family medical history: _____

Do you have any health concerns for other family members today? _____

Emergency Contact

Name: _____ Cell Phone: _____ Relation: _____

Current Health Conditions

Purpose of this visit: ❑ Wellness Care ❑ Health Concern ❑ Injury or Accident ❑ Other: _____

What is the MAIN symptom/pain/reason you are seeking chiropractic care

What health condition(s) bring you into our office? _____

Has this problem occurred before? ❑ No ❑ Yes *(If yes, when?)* _____

Have you received care/seen other doctors for this problem before? ❑ No ❑ Yes *(If yes, describe the type of care and whom)*

(If yes) How along ago? _____ What were the results of past treatment? _____

Rate your CURRENT pain/discomfort: [ ] /10 When did the problem begin? _____

Did you do something/did something happen that caused/aggravated the problem? (injury, accident, etc) ❑ No ❑ Yes
(If yes, explain) _____

The problem is: ❑ rapidly improving ❑ improving slowly ❑ about the same ❑ gradually worsening ❑ on and off ❑ unsure

What makes the problem BETTER? _____

What makes the problem WORSE? _____

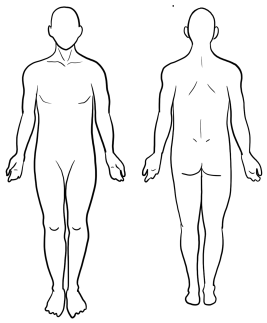
HOW OFTEN do you experience the problem? ❑ always ❑ often ❑ occasionally ❑ rarely ❑ monthly ❑ weekly ❑ daily (❑AM/❑PM)

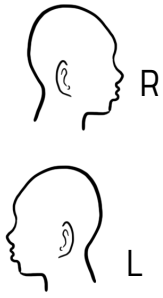
WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____

Does the problem RADIATE outward? ❑ No ❑ Yes *(If yes, where?)* _____

Any bowel or bladder problems since this problem began? ❑ No ❑ Yes *(If yes, explain)* _____

Directions: Put an X the area(s) that to your pain/symptom(s):





How would you describe the problem(s)?
❑ Dull ache ❑ Deep/boring ❑ Numb ❑ Pounding
❑ Stiff/tight ❑ Sharp/stabbing ❑ Radiating
❑ Tingling ❑ Burning ❑ Other: _____

Are there any SECONDARY health concerns you wish to bring to our attention?

Signature: _____

Outcome Assessment Tool

Quadruple Visual Analog Scale (QVAS)

Please put an X on the number that best describes the question being asked.

PROBLEM/CONCERN #1:_____

1. What is your pain RIGHT NOW?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2. What is your TYPICAL or AVERAGE pain?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3. What is your pain AT ITS BEST (How close to "0" is your pain at its best)?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4. What is your pain level AT ITS WORST (How close to "10" is your pain at its worst)?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

PROBLEM/CONCERN #2:_____

1. What is your pain RIGHT NOW?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2. What is your TYPICAL or AVERAGE pain?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3. What is your pain AT ITS BEST (How close to "0" is your pain at its best)?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4. What is your pain level AT ITS WORST (How close to "10" is your pain at its worst)?

no pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

Signature:_____

Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Pregnancy Questionaire

Previous Birth Experience

Is this your first pregnancy? ❑ Yes ❑ No If not, how many pregnancies previously _____

How many children do you have?_____ How many vaginal deliveries?_____ Cesarean deliveries?_____

Did you receive an epidural? ❑ Yes ❑ No ❑ Unknown

Was labor induced using Pitocin? ❑ Yes ❑ No ❑ Unknown

Was there any hip or back pain during labor? ❑ Yes ❑ No

Was baby in a suboptimal position during the pushing phase of labor? ❑ Yes ❑ No ❑ Unknown

Were there any operative devices used? ❑ Yes ❑ No ❑ Forceps ❑ Vacuum

Any postpartum complications or long term consequences? ❑ Yes ❑ No _____

Do you plan to follow the same plan as your previous delivery? ❑ Yes ❑ No

If no, what would you like to change? _____

Do you have any additional details about your previous birth(s) that you would like to share?

Conception + Early Pregnancy

When is your expected or calculated **due date**?_____ **How many weeks are you**?_____

Did you have any difficulty conceiving? ❑ No ❑ Yes, please explain: _____

Have you used any form of hormonal contraceptives? ❑ No ❑ Yes, which ones + how long?:

When was your last menstrual cycle?_____ What was your pre-pregnancy weight?_____

Have you experienced morning sickness? ❑ No ❑ Yes *(If yes, explain)* _____

Current Health Conditions

What type of exercise are you currently performing? _____

Please tell us about your current diet, and any dietary restrictions; _____

Have you taken any medications or supplements <u>during</u> your pregnancy? (prior use is asked in another section)
❑ No ❑ Yes, please explain: _____

Have you had any slips, falls or other physical traumas during this pregnancy? ❑ No ❑ Yes, please explain:

Have you had any major emotional stressors during this pregnancy? ❑ No ❑ Yes, please explain:

Your Birth Plan

What are your top 3 goals for this pregnancy?

1. _____

2. _____

3. _____

Do you currently have a birth plan? ❑ No ❑ Yes, please explain:

_____

_____

Are you taking any pre-natal or birthing classes? ❑ No ❑ Yes, please explain: _____

_____

Who is your OBGYN/Midwife? _____ Will he/she be present for delivery? ❑ Yes ❑ No

Who is your birth provider? _____

May we contact them about your care in our office? ❑ Yes ❑ No

Do you intend to have a birth coach or doula present? ❑ No ❑ Yes, please explain: _____

_____

Do you wish to have a natural labor and delivery? ❑ No ❑ Yes

Any concerns? _____

Do you wish to have a medicine free labor and delivery? ❑ No ❑ Yes

Health concerns for you or baby? _____

Your Post-Birth Plan

Do you plan on breastfeeding your child? ❑ No ❑ Yes

What do you intend to do for vaccines? _____

_____

What would you like to gain from chiropractic care during your pregnancy? _____

_____

Is there anything else you'd like to tell us about your pregnancy or birth plan? _____

_____

Do you have any other questions? _____

Chiropractic History

What would you like to gain from chiropractic care? ❑ Resolve existing challenge ❑ Overall wellness ❑ Both

Have you received chiropractic care in the past? ❑ No ❑ Yes

If yes, what is their name(s)? _____

What is their specialty? ❑ Pain Relief ❑ Nutritional ❑ Physical Therapy & Rehab ❑ Subluxation-based ❑ Other

If other specialty, specify? _____

Chiropractic + Health Lifestyle Goals

What are the health and lifestyle goals you to achieve while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

❑ Relieve Pain/ Discomfort	❑ Increase Energy	❑ Improve Mood/ Temperament
❑ Relieve Muscle Tension	❑ Get Adequate Sleep	❑ Improve Focus/ Concentration
❑ Restore Proper Function	❑ Increase Self Confidence	❑ Improve Athletic Performance
❑ Improve Flexibility/ Mobility	❑ Improve Diet/ Nutrition	❑ Restore Emotional Health
❑ Strengthen Immune System	❑ Maintain Health Body Weight	❑ Reduce Medication(s)
❑ Improve Posture	❑ Improve Work/ Life Balance	❑ Quit Unhealthy Habit:_____

❑ Decrease the *severity & intensity* of my pain/problem(s)

❑ Decrease the *frequency* of my pain/problem(s) (how often I experiences the pain/problem(s))

❑ By the end of my corrective chiropractic care, I hope they are able to... _____

_____

Personal Health History

List any vitamins or supplements that you took <u>prior to pregnancy</u>: ❑ N/A

(Please list the names & reason for taking):

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes *(If yes, explain)* _____

Help us identify past conditions or procedures that could be <u>related to your main issue</u>:

❑ N/A ❑ Past surgeries ❑ Childhood diseases ❑ Past injuries Explain: _____

_____

Have you experienced or been diagnosed with any of the following?

❑ N/A ❑ Pain that wakes you up at night ❑ Night Sweats ❑ Stroke ❑ Heart Attack ❑ Diabetes

Signature: _____

TRAUMAS: Physical Injury History

How often do you exercise? ❑ None ❑ 1-2x/week ❑ 3-5x/week ❑ Daily
What type of exercise? _____

How do you normally sleep? ❑ Back ❑ Side ❑ Stomach
How do you normally wake up? ❑ Refreshed and ready ❑ Stiff and tired
Do you commute to work? ❑ No ❑ Yes *(If yes, how many minutes per day)* _____ minutes

How many hours per day typically do you spend sitting at a desk or on a computer, tablet, or phone? _____ minutes

List any problems with flexibility (ex. Putting on shoes/socks, etc.): _____

What is your typical daily work activity? ❑ Sitting ❑ Standing ❑ Working at Computer
❑ Manual Labor ❑ Light Lifting ❑ Heavy Lifting ❑ Driving ❑ Other: _____

Indicate if you have experienced the following: ❑ N/A ❑ Been unconscious due to an illness or injury ❑ Fractured a bone
❑ Serious illnesses, operation, or health emergency ❑ Auto accident
Explain (include year(s): _____

Notable childhood injuries? ❑ No ❑ Yes*(If yes, explain)* _____

Youth or college sports? ❑ No ❑ Yes *(If yes, list major injuries)* _____

THOUGHTS: Emotional Stresses + Challenges

Please rate your STRESS for each:

	1 - None	2	3 - Moderate	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

Are there other emotional stresses or challenges you'd like to tell us about? _____

TOXINS: Chemical + Environmental Exposure

Please rate your CONSUMPTION for each:

	1 - None	2	3 - Moderate	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

Were you taking any over-the-counter or prescription medications prior to pregnancy? ❑ No ❑ Yes*(If yes, list which and why)*

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Signature: _____

Activities of Daily Living

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE			CAN NOT COMPLETE	N/A
	Without Pain or Difficulty	With *Minimal* Pain or Difficulty	With *Significant* Pain or Difficulty	Due to Pain	
Bathe/ Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Get Dressed	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑

Signature: _____

Review of Systems + Organ Dysfunction for Self + Family

DIRECTIONS: Check the box(es) that apply to conditions that apply to you or your family members currently suffer from/have suffered from in the past. (Adopted? ❑ No ❑ Yes)

Condition	*SELF*	CHILD	SIBLING	PARENT	GRANDPARENT
Acid Reflux/ Heartburn/GERD	❑	❑	❑	❑	❑
ADHD/ADD	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑
Arthritis/ Joint Pain	❑	❑	❑	❑	❑
Asthma/Difficulty Breathing	❑	❑	❑	❑	❑
Autism Spectrum	❑	❑	❑	❑	❑
Bed Wetting	❑	❑	❑	❑	❑
Behavioral Problems	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Carpal Tunnel Syndrome	❑	❑	❑	❑	❑
Chest Pain	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Difficulty Sleeping	❑	❑	❑	❑	❑
Disc Problems	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑	❑
Headaches/Migraines	❑	❑	❑	❑	❑
Hemorrhoids	❑	❑	❑	❑	❑
High/Low Blood Pressure	❑	❑	❑	❑	❑
Infertility	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑
Menstrual Dysfunction	❑	❑	❑	❑	❑
Mood Changes/ Irritability	❑	❑	❑	❑	❑
Numbness/Tingling	❑	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑	❑
Sinus Problems	❑	❑	❑	❑	❑
Swelling of Legs/Feet	❑	❑	❑	❑	❑
TMJ/Jaw Pain	❑	❑	❑	❑	❑
Tremors	❑	❑	❑	❑	❑

Organic/System Problems | *Select ALL that apply:* ❑ Digestive ❑ Gallbladder ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual ❑ Other(s) Explain:

None of the above apply to me ❑

Signature: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members

Harmony Family Chiropractic Notice of Privacy Policy

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. **Keep this page for your records.**

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership– in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Harmony Family Chiropractic at (919) 234-0505. If Dr. Jaylene Bair and/or Dr. Christopher Hopkins are unavailable, you may make an appointment with our team to see him/her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

If you would like a copy please request one from the front desk

Harmony Family Chiropractic Notice of Privacy Policy (Continued)

I have received a copy of Harmony Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Name (Printed): _____ **Date:** _____

Signature: _____ **Date of Birth:** _____

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Harmony Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Signature: _____ **Date:** _____

Authorization for X-ray POSTPARTUM

You will <u>NOT</u> receive x-rays during your pregnancy.

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctors of Harmony Family Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

At your request, we will provide you with a copy of your x-rays in our file. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations.

I understand that if necessary, for the best quality of care, I may receive x-rays **POSTPARTUM**.

Signature: _____ **Date:** _____

Authorization for Release of Health Information

I authorize Harmony Family Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Harmony Family Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Harmony Family Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: _____ **Date:** _____

Photo and Social Media Consent

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.

For valuable consideration, I herby irrevocably consent to and authorize the use and reproduction by Harmony Family Chiropractic, or anyone authorized by Harmony Family Chiropractic, of any and all photographs/videos which were taken of my child, for the purpose of promotional TV, website, social media and/or print as whatsoever, without further compensation to me. All negative and positives, together with the prints shall constitute the property of Harmony Family Chiropractic, solely and completely. Any information voluntarily provided by a patient, including first name, shall also be used in conjunction with the above listed information for the purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Harmony Family Chiropractic, to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws). Do not sign if you would like for photos not to be taken. Thank you

Signature: _____

Cancellation/ Broken Appointment Policy

Our commitment to your great chiropractic care begins with a defined schedule in which we have allotted specific amounts of time for you and other patient abased on your specific needs. With said, we understand that "life" happens and results in needed changes to our
day to day schedule that may prevent us from keeping an appointment. We respectfully request at least 12 hour advanced notice if you need to cancel an appointment. Giving us as much notice as possible ensures that someone else is able to take advantage of the time that was allotted to you.

An appointment that is cancelled with less than 12 hours' notice or an appointment that is not canceled at all in which the patient fails to appear to is considered a broken appointment. Broken appointments delay the success of your treatment and the treatment of other patients. Therefore, any broken appointments will result in a $25.00 office fee.

Thank you in advanced for your compliance without cancellation and broken appointment policies. Please know that all policies
are in place to ensure a great chiropractic experience for you and your family. Again, we look forward to serving your every chiropractic need!

Please initial below that you read and understand the cancellation and broken appointment policy.

Signature: _____

*IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

Written Consent for Child

Name of practice member who is a minor/child _____I authorize Dr. Jaylene Bair, Dr. Christopher Hopkins and any and all harmony family chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Harmony Family Chiropractic.

Guardian Name (Printed): _____ Date: _____

Guardian Signature: _____ Guardian DOB: _____