320 Ichord Ave
Ste J 1 and 2
Waynesville, MO 65583

Ph: 573-774-4177
Fax: 573-774-3921

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Child's Name: ______ Date of Birth: ______ Gender: ______

Parent/Guardian Name(s): ______ Child's Social Security #: ______

Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

Cell Phone: ______ Home Phone: ______ Work Phone: ______

Email: ______ Height: ______ Weight: ______

Who is your primary care physician?

______

2. How did you hear about us? (please select all that apply & list who in the box that appears)

- ☐ Current Patient (list who) ______
- ☐ Professional Referral/Doctor (list who) ______
- ☐ Google Search ______
- ☐ Facebook ______
- ☐ Community Partner (list who) ______
- ☐ Other (specify) ______

3. Is your child receiving care from any other health professionals?

- ○ Yes
- ○ No

4. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Others:

____

5. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Others:

____

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

____
____
____
____

7. Please describe when your child's issues first began and how they've progressed since:

____
____
____
____

8. What makes things better?

____
____
____
____

9. What makes things worse?

______

HEALTH GOALS FOR YOUR CHILD

10. What are your top three health goals for your child:

1. ______

2. ______

3. ______

11. What would you like to gain from chiropractic care?

- Resolve existing condition
- Overall wellness + prevention
- Both

12. Have you ever visited a chiropractor?

- Yes
- No

If yes, what is their name:

______

13. What is their specialty?

- Pain Relief
- Physical Therapy & Rehab
- Nutritional
- Subluxation-based
- Other

If other, specify:

______

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

14. Any fertility challenges?

- Yes
- No

15. If yes, please explain:

____

____

____

____

16. Did mother smoke?

- Yes
- No

If yes, how many per week?

____

17. Did mother drink?

- Yes
- No

If yes, how many per week?

____

18. Did mother exercise?

- Yes
- No

19. If yes, please explain:

____

____

____

____

20. Was mother ill?

- Yes
- No

21. If yes, please explain:

____

____

____

____

22. Any ultrasounds?

- Yes
- No

23. If yes, please explain:

24. Please explain any notable episodes of emotional or physical stress during your pregnancy:

25. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

26. Child's birth was:
   - Vaginal Birth
   - Scheduled C-section
   - Emergency C-section

   At how many week's was your child born?

27. Child's birth was:
   - At home
   - At a hospital
   - At a birthing center
   - Other

   If other, specify:

28. Birth Provider's Name:

29. Please check any applicable interventions or complications:
   - Breech
   - Manual assistance
   - Vacuum extraction
   - None of the above
   - Induction
   - Epidural
   - Forceps
   - Pain meds
   - Episiotomy
   - Cord-wrapped

   If other, specify:

30. Please describe any other concerns or notable remarks about your child's labor and/or delivery.

____
____
____
____

31. Child's birth weight: ____________ Child's birth height: ____________ APGAR score at birth: ____________ APGAR score at 5 minutes: ____________

GROWTH & DEVELOPMENT HISTORY

32. Is/was your child breastfed?

- Yes
- No

If yes, how long?

____

33. Difficulty with breastfeeding?

- Yes
- No

If yes, is there a certain side that is more difficult for them?

____

34. Did they ever use formula?

- Yes
- No

35. If yes:

At what age:

____

36. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

- Yes
- No

37. If yes, please explain:

____
____
____
____

38. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

- Yes
- No

39. If yes, please explain:

____

____

____

____

40. At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

41. Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
1		
2		
3		

42. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

43. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

44. Have you chosen to vaccinate your child?

- No
- Yes, on schedule
- Yes, on a delayed or selective schedule

45. If yes, please list any vaccination reactions:

____

46. Has your child received any antibiotics?

- Yes
- No

47. If yes, how many times and list reason:

____

48. Any difficulty with bonding or social development?

- Yes
- No

49. If yes, please explain:

____

50. Night terrors or difficulty sleeping?

- Yes
- No

51. If yes, please explain:

52. Behavioral, social or emotional issues?

- Yes
- No

53. If yes, please explain:

54. How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

55. How would you describe your child's diet?

- Mostly whole, organic foods
- Pretty average
- High amount of processed foods

56. Are there other health concerns, or is there anything else you'd like us to know about your child?

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

57.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		

Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		
Depression & Lack of Confidence		
Lightheadedness & Dizziness		
Frequent Naseau & Malaise		
Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		

Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn's, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		
Low Back Pain & Stiffness		
Lumbopelvic / SI Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

Patient or Parent/Guardian

______________________________ Signature

______________ Date

OGLE CHIROPRACTIC & REHAB CENTER, LLC
320 Ichord Ave. Ste J Waynesville, MO 65583
573-774-4177

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ogle Chiropractic & Rehab Center, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Please list those whom we may give your information to:

Name: ______________________________ Phone#: ________________

Name: ______________________________ Phone#: ________________

Name: ______________________________ Phone#: ________________

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. _______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. _______Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ______________
Patient or Legally Authorized Individual Signature Date

____ ______________
Print Patient's Full Name Time

____ ______________
Witness Signature Date

Office Fee Schedule and Financial Policy

Service	**Charges**
Consultation	N/C
Initial Exam (Required)	$80
Progress Report	$40
X-Rays (per set) 2 views min.	$75
Adjustment	$40
Acupuncture	$45
Spinal Decompression	$50 per session
X-Ray Consult	$30
E-Stim	$15
Cupping	$20
Intersegmental Traction (Roller) Table	$15
Ultrasound	$25
B12 Injection	$25 each
IMR Mat	$25
Diathermy	$15
No Call/No Show to Appt	$25
ART (Active Release Technique)	$30.00

Financial Policy and Chiropractic Treatment Plans

Our responsibilities: We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. We will provide you the best service possible to meet your needs. We will correct any errors we have made if there is a dispute. We are available to answer any questions and will do our best to serve you in a polite and courteous manner. We will provide you a superbill at your request. We accept cash, credit/debit, and checks for payment of services rendered on each day. NOTE: There will be a returned check fee assessed if one is received.

Your responsibilities: Payment is expected at time of service unless you arrange a payment plan set up between you and the doctor. Know your insurance carriers' requirements for filing insurance claims. Every insurance carrier is different. We will verify your insurance coverage for you, however, remember your agreement with your insurance company is between you and them. Please contact the member services telephone number on the back of your card for more information. Information given by your insurance company is not a guarantee of coverage.

Cancellations: Please make any cancellations with at least 24 hours' notice or you will be billed a $25 no call/no show fee.

Collections: I fully understand that I am financially responsible for and agree to pay all charges. In consideration of the chiropractic services furnished to me, I hereby agree to pay Ogle Chiropractic and Rehab Center, LLC any balance due within sixty days from presentation of my bill. In the event of default, I promise to pay legal interest on Indebtedness together with 50% collection costs and attorney fees as may be required to effect collections.

Prices are subject to change at any time
I have read and I understand the above policy.

Patient Signature ______________________________ Date____________________

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize **Ogle Chiropractic and Rehab Center, LLC** and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also with to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment/treatment plan.

Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with the specific pamphlets and other literature and practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

   I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and purposed course of care and treatments by the Practice.

______________________ ______________________________/__________

Patient's Printed Name | Patient's Signature | Date

Patient counseled by:____________________________________

Signature of doctor

Patient name: ____________________ Signature: ______________________________ Date: __________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

☐ A the pain comes and goes and is vary mild.
☐ B The pain is mild and does not vary much.
☐ C The pain comes and goes and is moderate.
☐ D The pain is moderate and does not vary much.
☐ E The pain comes and goes and is severe.
☐ F The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

☐ A I would not have to change my way of washing or dressing in order to avoid pain.
☐ B I do not normally change my way of washing or dressing even though it causes some pain.
☐ C Washing and dressing increase the pain but I manage not to change my way of doing it.
☐ D Washing and dressing increase the pain and I find it necessary to change my way of doing it.
☐ E Because of the pain I am unable to do some washing and dressing without help.
☐ F Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

☐ A I can lift heavy weights without extra pain.
☐ B I can lift heavy weights but it gives extra pain.
☐ C Pain prevents me from lifting heavy weights off the floor.
☐ D Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
☐ E Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ F I can only lift very light weights at the most.

Section 4 – Walking

☐ A I have no pain on walking.
☐ B I have some pain with walking but it does not increase with distance.
☐ C I cannot walk more than One Mile without increasing pain.
☐ D I cannot walk more than 1/2 Mile without increasing pain.
☐ E I cannot walk more than 1/4 Mile without increasing pain.
☐ F I cannot walk at all without increasing pain.

Section 5 – Sitting

☐ A I can sit in any chair as long as I like.
☐ B I can only sit in my favorite chair as long as I like.
☐ C Pain prevents me from sitting more than one hour.
☐ D Pain prevents me from sitting more than 30 minutes.
☐ E Pain prevents me from sitting more than 10 minutes.
☐ F I avoid sitting because it increases pain straight away.

Section 6 – Standing

☐ A I can stand as long as I want without pain.
☐ B I have some pain on standing but it does not increase with time.
☐ C I cannot stand for longer than one hour without increasing pain.
☐ D I cannot stand for longer than 1/2 hour without increasing pain.
☐ E I cannot stand for longer than 10 minutes without increasing pain.
☐ F I avoid standing because it increases pain straight away.

Section 7 – Sleeping

☐ A I get no pain in bed.
☐ B I get pain in bed but it does not prevent me from sleeping well.
☐ C Because of pain my normal nights sleep is reduced by less than 1/4.
☐ D Because of pain my normal nights sleep is reduced by less than 1/2.
☐ E Because of pain my normal nights sleep is reduced by less than 3/4.
☐ F Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ A My social life is normal and gives me no pain.
☐ B My social life is normal but increases the degree of my pain.
☐ C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
☐ D Pain has restricted my social life and I do not go out very often.
☐ E Pain has restricted social life to my home.
☐ F I have hardly any social life because of the pain.

Section 9 – Traveling

☐ A I get no pain while traveling.
☐ B I get some pain while traveling but none of my usual sorts of travel make it any worse.
☐ C I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
☐ D I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ E Pain restricts all forms of travel.
☐ F Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

☐ A My pain is rapidly getting better.
☐ B My pain fluctuates but overall is definitely getting better.
☐ C My pain seems to be getting better but improvement is slow at the present.
☐ D My pain is neither getting better or worse.
☐ E My pain is gradually worsening.
☐ F My pain is rapidly worsening.

Patient name: ______________________ Signature: ____________________________ Date: __________

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

☐ A I have no pain at the moment.
☐ B The pain is mild at the moment.
☐ C The pain comes and goes and is moderate.
☐ D The pain is moderate and does not vary much.
☐ E The pain is severe but comes and goes.
☐ F The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

☐ A I can look after myself without causing extra pain.
☐ B I can look after myself normally but it causes extra pain.
☐ C It is painful to look after myself and I am slow and careful.
☐ D I need some help, but manage most of my personal care.
☐ E I need help every day in most aspects of self care.
☐ F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ A I can lift heavy weights without extra pain.
☐ B I can lift heavy weights, but it causes extra pain.
☐ C Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
☐ D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ E I can lift very light weights.
☐ F I cannot lift or carry anything at all.

Section 4 – Reading

☐ A I can read as much as I want to with no pain in my neck.
☐ B I can read as much as I want to with slight pain in my neck.
☐ C I can read as much as I want with moderate pain in my neck.
☐ D I cannot read as much as I want because of moderate pain in my neck.
☐ E I cannot read as much as I want because of severe pain in my neck.
☐ F I cannot read at all.

Section 5 – Headaches

☐ A I have no headaches at all.
☐ B I have slight headaches which come infrequently.
☐ C I have moderate headaches which come infrequently.
☐ D I have moderate headaches which come frequently.
☐ E I have severe headaches which come frequently.
☐ F I have headaches almost all the time.

Section 6 – Concentration

☐ A I can concentrate fully when I want to with no difficulty.
☐ B I can concentrate fully when I want to with slight difficulty.
☐ C I have a fair degree of difficulty in concentrating when I want to.
☐ D I have a lot of difficulty in concentrating when I want to.
☐ E I have a great deal of difficulty in concentrating when I want to.
☐ F I cannot concentrate at all.

Section 7 – Work

☐ A I can do as much work as I want to.
☐ B I can only do my usual work, but no more.
☐ C I can do most of my usual work, but no more.
☐ D I cannot do my usual work.
☐ E I can hardly do any work at all.
☐ F I cannot do any work at all.

Section 8 – Driving

☐ A I can drive my car without neck pain.
☐ B I can drive my car as long as I want with slight pain in my neck.
☐ C I can drive my car as long as I want with moderate pain in my neck.
☐ D I cannot drive my car as long as I want because of moderate pain in my neck.
☐ E I can hardly drive my car at all because of severe pain in my neck.
☐ F I cannot drive my car at all.

Section 9 – Sleeping

☐ A I have no trouble sleeping.
☐ B My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ C My sleep is mildly disturbed (1-2 hours sleepless).
☐ D My sleep is moderately disturbed (2-3 hours sleepless).
☐ E My sleep is greatly disturbed (3-5 hrs. sleepless).
☐ F My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ A I am able engage in all recreational activities with no pain in my neck at all.
☐ B I am able engage in all recreational activities with some pain in my neck.
☐ C I am able engage in most, but not all recreational activities because of pain in my neck.
☐ D I am able engage in a few of my usual recreational activities because of pain in my neck.
☐ E I can hardly do any recreational activities because of pain in my neck.
☐ F I cannot do any recreation activities at all.

Ogle Chiropractic and Rehab Center, LLC Roland-Morris Questionnaire

Patient name:______________________________ Signature:______________________________ Date: __________

Previous Date & Score________ ____%increase/decrease Score___________

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe your pain during every day activities.

1[ ] I stay at home most of the time because of my pain.

2[ ] I change position frequently to try to get my comfortable.

3[ ] I walk more slowly than usual because of my pain.

4[ ] Because of my pain, I am not doing any jobs that I usually do around the house.

5[ ] Because of my pain, I use a handrail to get upstairs.

6[ ] Because of my pain, I lie down to rest more often.

7[ ] Because of my pain, I have to hold on to something to get out of an easy chair.

8[ ] Because of my pain, I try to get other people to do things for me.

9[ ] I get dressed more slowly than usual because of my pain.

10[ ] I only stand up for short periods of time because of my pain.

11[ ] Because of my pain, I try not to bend or kneel down.

12[ ] I find it difficult to get out of a chair because of my pain.

13[ ] I have pain almost all the time.

14[ ] I find it difficult to turn over in bed because of my pain.

15[ ] My appetite is not very good because of my pain.

16[ ] I have trouble putting on my sock (or stockings) because of the pain.

17[ ] I can only walk short distances because of my pain.

18[ ] I sleep less well because of my pain.

19[ ] Because of my pain, I get dressed with the help of someone else.

20[ ] I sit down for most of the day because of my pain.

21[ ] I avoid heavy jobs around the house because of my pain.

22[ ] Because of pain, I am more irritable and bad tempered with people than usual.

23[ ] Because of my pain, I go upstairs more slowly than usual.

24[ ] I stay in bed most of the time because of my pain.

Consent to X-Ray

Patients Name: ______________________________

I hereby authorize Dr. ______________________ and whomever he/she designates as his/her assistant's to take x-rays of myself (or said minor).

Dated this __________ day of _________________ 20_____

Witness ____
Printed Name

____
Signature

Patient ____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if patient is a minor)

Pregnancy Warning

Patient Name____ Date_______________

◊ I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

◊ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for x-ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	Yes	No	Don't Know
I could be pregnant:	Yes	No	Don't Know
I have an IUD:	Yes	No	Don't Know
I have had a tubal ligation:	Yes	No	Don't Know
I am late with my menstrual period:	Yes	No	Don't Know
I am taking oral contraceptives:	Yes	No	Don't Know
I have had a hysterectomy:	Yes	No	Don't Know
I have irregular menstrual periods:	Yes	No	Don't Know

My last menstrual period began on: _________________________

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed now.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-rays negatives will remain the property of this office.

____
Patient Signature Date

____
Guardian or Parent Signature Authorizing Care Date

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Waynesville, MO 65583
W: 573-774-4177
Fax: 573-774-3921
www.oglechiropractic.com

OGLE CHIROPRACTIC PHOTO RELEASE

I, on behalf of myself and/or my minor children, hereby grant Ogle Chiropractic, LLC, (OC) and its officers, chiropractors, owners and employees the right to take photographs of myself and my minor child(ren), while on the premises of OC or while attending any offsite event hosted or otherwise sponsored by OC or any of OC's affiliate businesses. I further give permission for the use of such photographs in the advertising, business, web-hosted, social media account, or educational materials promulgated, created, designed, purchased or otherwise used by OC for purposes of promoting OC. I hereby waive any applicable right of privacy that I may assert on behalf of myself or my minor child(ren), and further agree that such photos may be used for any additional lawful purposes related to promoting OC and it's affiliates as well as chiropractic treatment in general. To the extent that such disclosures show a doctor/patient relationship, I hereby waive such privilege on behalf of myself and my minor child(ren) for the limit purposes enumerated herein specifically related to photographic material.

I have fully read and understand the implications of this wavier and release and hereby affix my signature in acknowledgment of my agreement with such terms. By affixing my signature below, I am also confirming that I am at least 18 years of age, or, if signing on behalf of a minor child, that I am at least 18 years of age.

I am at least 18 years of age and have read and understand the above:

Patient Name: ____

If under 18 years of age the legal guardian or parent has read and understands the above:

Parent/Guardian Name: ______________________________________

Parent/Guardian

____ ______________________

Patient Signature Date