Oasis Chiropractic and Laser Center
106 N Main Street, Red Oak, OK 74563
918-448-6054 // oasischiropractic.net

Child's Name: _____ M.I.: _____ Last Name: _____ Date:_____
Child's Nickname: _____ Child's Age:_____ DOB: __ __ /__ __ /__ __ Male / Female
Parent / Guardian Names: _____
Siblings' Names & Ages:_____
Address: _____ City: _____State:_____ Zip:_____
Parents' Email: _____
Home #:_____ Cell #: _____ Work #: _____
Family Doctor's Name:_____ Phone #:_____

Please pick the purpose for your child's visit: ▢ Wellness Consult ▢ Injury/ Accident ▢ Chiropractic Care
Do we have permission to contact your doctor regarding your child's care in our office? ____Yes ____No
Has your child ever received chiropractic care?: ____Yes ____No
If yes, who has your child seen previously?: _____ Date last visit: _____
The reason for the last visit: _____
Other professionals seen for this condition: _____
Results with that treatment?: _____
Additional Emergency Contact:_____ Relation: _____ Phone #:_____
Have you had an auto accident? (X if applies): ▢ 0-6mo ▢ 6 mo-1 yr ▢ 1-3yrs ▢ 3+yrs ▢ Never
Had a recent fall/other accident? (X if applies): ▢ 0-6mo ▢ 6 mo-1 yr ▢ 1-3yrs ▢ 3+yrs ▢ Never

How Did You Hear About This Office?

▢ Existing Patient: _____ ▢ Walk-In/Drive-By
▢ Ad:_____ ▢ Massage Therapist :_____
▢ Other: _____ ▢ Internet: _____

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Present Health Concerns

Major Complaint: _____

Minor Complaint: _____

When did this complaint begin?: _____ Is this complaint: ❑ frequent ❑ constant ❑ come & go

Does the complaint radiate?: ❑ Yes ❑ No If Yes, where?: _____

What makes this worse?: _____

What makes this better?:

_____

Is this problem worse during a certain time of the day?: ❑ Yes If Yes, When?: _____ ❑ No

Does this interfere with the child's: ❑ Sleep? ❑ Eating ? ❑ Daily Routine?

Often seemingly unrelated symptoms can manifest as other health concerns… Please mark if your child has had any of the following:

□ headaches	□ chest pressure	□ weight loss
□ dizziness	□ numbness in hand(s)	□ neck pain
□ weight gain	□ fainting	□ loss of smell
□ irritability	□ cold sweats	□ allergies
□ frequent colds	□ weakness	□ low back pain
□ fatigue	□ ears buzzing	□ loss of taste
□ sinus congestion	□ bronchitis	□ constipation
□ fevers	□ heartburn	□ radiating pain
□ depression	□ poor coordination	□ light sensitivity
□ sore throats	□ pneumonia	□ diarrhea
□ heart palpitations	□ muscle cramps	□ sleeping problems
□ loss of balance	□ vision changes	□ urinary problems
□ ear pain/infections	□ difficulty breathing	□ numbness in leg(s)
□ numbness in feet	□ upper back pain	□ reduced mobility
□ loss of concentration	□ loss of memory	□ bloating/gas
□ asthma	□ shortness of breath	□ stiffness

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Birth History

What was the child's gestational age at birth? _____ Weeks.
Birth weight _____ lbs _____ oz Birth length _____ inches

Was your child's birth: □ at home □ in a birthing center □ hospital □ other _____
Was the birth considered: □ medical □ midwife Duration of birth: _____ hours
Was child born : □ cephalic (head first) □ breech (feet first) □ N/A (C-Section)
Were there any complications? □ Yes □ No If Yes, please explain: _____
_____
Assistances used during delivery: □ Forceps □ Vacuum extraction □ C-section □ Episiotomy
was labor: □ Spontaneous □ Induced
Did the mother have during the birth?: □ medications □ epidurals
Is there anything else we need to know about the birth: □ Yes □ No If Yes, please explain: _____
_____

Growth & Development

Was the infant alert & responsive within 12 hours of delivery? □ Yes □ No If No, please explain:_____
_____
Do you consider the child's sleeping pattern norman? □ Yes □ No If No, please explain: _____
_____

Family Health History

Please note any health problems (cancer, hereditary conditions, diabetes, heart disease) that are present in:
Mother's family: _____
Father's family: _____
Siblings: _____

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Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) □ Yes □ No If Yes, please explain:

_____

Any evidence of birth trauma to the infant? □ bruising □ odd shaped head □ stuck in birth canal
□ fast or excessively long birth □ respiratory depression □ cord around neck

Any falls from couches, beds, change tables, etc? □ Yes □ No

If Yes, please explain:_____

Any traumas resulting in bruises, cuts, stitches or fractures? □ Yes □ No

If Yes, please explain: _____

Any hospitalization or surgeries? □ Yes □ No If Yes, please explain: _____

Any sports played? _____

Is a school backpack used? □ Yes □ No Is it □ Heavy □ Light?

Chemical Stressors

Was the child breast-fed? □ Yes □ No If Yes, how long: _____

Formula was introduced at what age: _____ Which formula? _____

Other beverages: □ cow milk □ goat milk □ almond milk □ other _____ Introduced at what age: ___

Began solid foods at what age: _____ Types of solid foods: _____

Food/Juice intolerance? □ Yes □ No If Yes, please explain: _____

_____

Is your child on or have taken any medications?

_____

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Oasis Chiropractic and Laser Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the
Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Timothy Nix. If you would like further information about our privacy policies and practices please contact: Dr. Timothy Nix. This notice is effective as of January 1, 2025, and any alterations or amendments made herein will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

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TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be checked out.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

FOR MINORS: I, _____ being the parent or legal guardian of
(Print Guardian Name)

_____,
(Print Minor's Name)

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

_____ _____
(SIGNATURE) **(DATE)**

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Payment is due at the time of services. If any payment arrangements need to be made, please speak with Dr. Timothy Nix.

Please sign and date that you understand and agree to our policy. If there are any questions please ask us before signing.

Thank You!

SIGNATURE of Parent / Guardian: _____ DATE: _____