SINGER CHIROPRACTIC WELLNESS CENTER 3B SYNERGY SYSTEMS PEDIATRIC & ADOLESCENT INTAKE FORM (AGE 0–18)

PATIENT INFORMATION

Child's Full Name: _____

Date of Birth: _____/_____/____ Age: _____ Sex: ☐ Male ☐ Female

Parent/Guardian Name(s): _____

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

Parent Cell: _____ Parent Email: _____

By documenting your email address on this page, you are agreeing that health information for your child can be shared via email between you and Singer Chiropractic Wellness Center.

Pediatrician / Primary Care Provider: _____

Phone: _____

Emergency Contact (if different): _____ Phone: _____

OUR APPROACH

Children develop through tightly connected structural, neurological, and biochemical systems. When one system is stressed, the others often compensate. Rather than focusing only on isolated symptoms, we evaluate how your child is developing and adapting across three interconnected domains:

Body (structural development, posture, coordination, and mechanical integrity) Brain (nervous system regulation, sensory processing, emotional balance, sleep, and learning) Biochemistry (immune resilience, inflammation patterns, gut health, nutrient sufficiency, and metabolic stability)

Our goal is to support healthy development, improve resilience, and address root contributors early — before small stress patterns become long-term challenges.

PRIMARY CONCERNS

What are your child's main health concerns?

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

How have these concerns changed over time? ☐ Improved ☐ Stayed the same ☐ Worsened ☐ Fluctuate

List other doctors consulted for these conditions:

1. _____
2. _____

Have you previously received chiropractic or systems-based corrective care? ☐ Yes ☐ No

Have you tried any treatments, therapies, diet changes, or medications?

3B SYNERGY SYSTEMS FULL HEALTH PROFILE

GENETIC FOUNDATIONS

Your child's genes influence how their Body (structure and connective tissue), Brain (nervous system development and regulation), and Biochemistry (inflammation, immune balance, and detox pathways) function. Genetics do not determine destiny, but they can influence resilience, recovery speed, stress tolerance, and long-term developmental stability.

☐ Genetic testing has been performed ☐ No genetic testing has been performed ☐ Unsure

If testing has been performed, list any known variants or findings:

Family history of:

☐ Early disc degeneration or chronic back problems ☐ Scoliosis ☐ Joint hypermobility ☐ Autoimmune disease ☐ Early-onset arthritis ☐ Neurodegenerative disease ☐ Chronic anxiety or mood disorders ☐ Significant chemical sensitivity ☐ Type 2 diabetes ☐ Early heart disease (before age 60) ☐ Stroke ☐ Obesity or metabolic syndrome ☐ None known

When completing this form, consider your child's entire history, including infancy. For any item that applies, write "C" (current) or "P" (past) next to the checkbox.

SECTION 1: BODY (STRUCTURAL DEVELOPMENT)

PREGNANCY & BIRTH HISTORY

☐ Maternal stress during pregnancy ☐ Maternal antibiotic use during pregnancy ☐ Gestational diabetes or high blood pressure ☐ Induced labor ☐ Epidural ☐ Cesarean section ☐ Forceps or vacuum-assisted delivery ☐ Prolonged labor ☐ NICU stay ☐ Low birth weight ☐ High birth weight

INFANT STRUCTURAL PATTERNS

☐ Difficulty latching or nursing ☐ Preferred head turning to one side ☐ Flat head (plagiocephaly) ☐ Colic ☐ Reflux ☐ Chronic constipation

GROSS MOTOR DEVELOPMENT

☐ Delayed rolling, crawling, or walking ☐ Skipped crawling ☐ Toe walking ☐ Frequent falls ☐ Poor coordination ☐ Sports injuries

CURRENT STRUCTURAL CONCERNS

☐ Headaches ☐ Neck or back pain ☐ Growing pains ☐ Scoliosis ☐ Joint hypermobility ☐ Postural concerns

SECTION 2: BRAIN (NERVOUS SYSTEM & DEVELOPMENT)

SLEEP & REGULATION

☐ Difficulty falling asleep ☐ Frequent night waking ☐ Night terrors ☐ Bedwetting (age appropriate) ☐ Difficulty calming after stress

SENSORY & BEHAVIORAL

☐ Sensitive to sound/light/touch ☐ Emotional outbursts ☐ Anxiety ☐ Difficulty with transitions ☐ Attention concerns ☐ Hyperactivity ☐ Mood swings ☐ Screen time greater than 3 hours/day

COGNITIVE & LEARNING

☐ Speech delay ☐ Learning challenges ☐ Difficulty concentrating ☐ Memory concerns ☐ Concussion history

SECTION 3: BIOCHEMISTRY (IMMUNE & METABOLIC DEVELOPMENT)

EARLY FEEDING HISTORY

☐ Breastfed Duration: _____ ☐ Formula fed ☐ Mixed feeding

Age solids introduced: _____

IMMUNE HISTORY

☐ Recurrent ear infections ☐ Frequent colds ☐ Chronic congestion ☐ Eczema ☐ Asthma ☐ Food allergies ☐ Autoimmune diagnosis

ANTIBIOTIC & MEDICAL EXPOSURE

☐ Multiple antibiotic courses ☐ Vaccination within last 12 months ☐ Significant reaction following vaccine or infection ☐ Hospitalization for infection

DIGESTIVE & METABOLIC

☐ Constipation ☐ Diarrhea ☐ Bloating ☐ Sugar cravings ☐ Poor appetite ☐ Picky eating ☐ Low energy

DIETARY PATTERN

How would you describe your child's eating style? ☐ Balanced whole-food diet ☐ Picky eater ☐ High processed food intake ☐ High sugar intake ☐ Limited protein intake ☐ Limited vegetable intake

ENVIRONMENTAL EXPOSURES

☐ Mold exposure ☐ Daycare with frequent illness exposure ☐ Household smokers ☐ Recent home renovation ☐ High screen exposure before bed

MEDICATIONS

Prescription and over-the-counter medications are designed to alter, suppress, or regulate specific biochemical pathways and physiological responses in the body. Understanding current medication use helps us evaluate system interactions, potential side effects, and how your body is currently being medically managed.

List all current medications (include dose and frequency):

NUTRITIONAL SUPPLEMENTS

Nutritional supplements are used both as foundational support and as targeted system-restoration tools within this practice. They are intended to support and optimize natural physiological processes, including inflammation regulation, detoxification pathways, mitochondrial energy production, hormone balance, and nervous system function. Recommendations may be guided by symptom patterns, examination findings, and system-based evaluation, and when appropriate, refined by laboratory or genetic testing. Unlike medications, which are designed to alter or suppress specific biochemical pathways, supplements are used to nourish, reinforce, and help restore the body's existing systems toward improved resilience and stability.

Foundational Support:

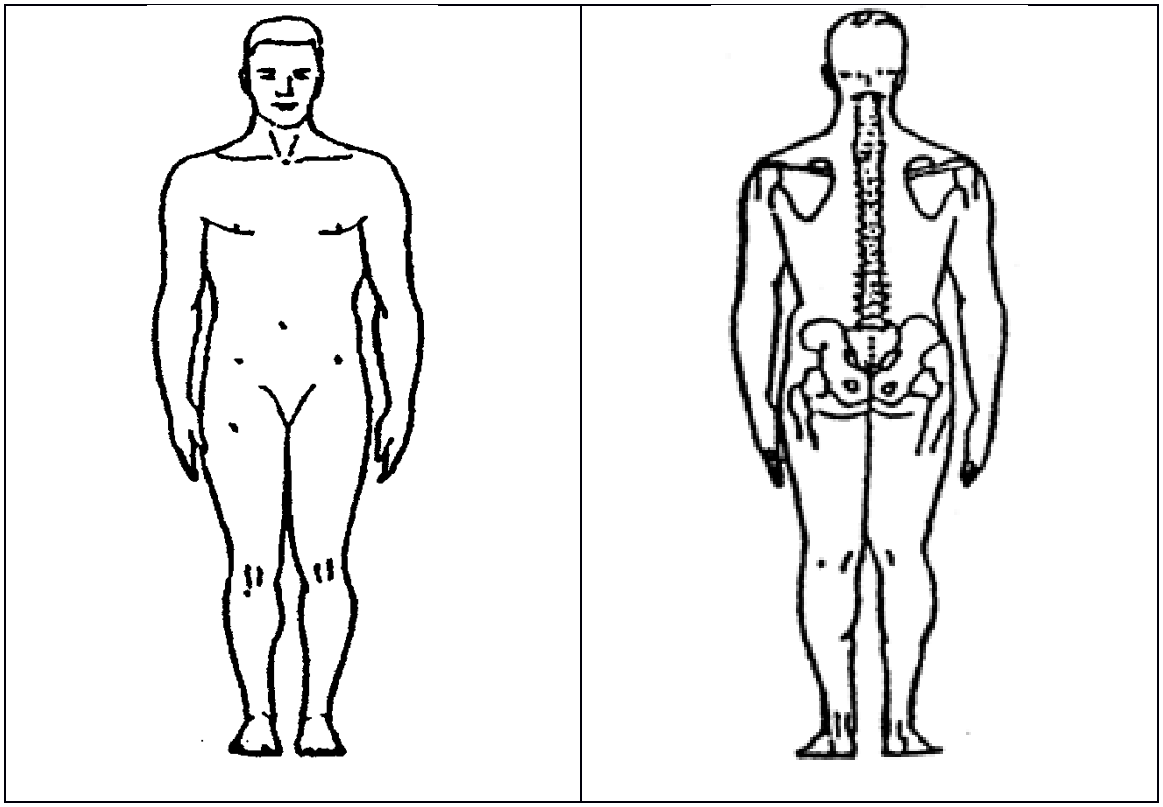
☐ Vitamin D ☐ Omega-3 ☐ Multivitamin ☐ Multimineral ☐ None

List all supplements (include dose and frequency):

Allergies: ☐ Yes ☐ No If yes, list:

If your child is experiencing any health problems, please mark the exact location of the problem on the diagram below

COMPLETE THESE DIAGRAMS



SURGICAL & MEDICAL HISTORY

Details:

Dental History:

Oral health can influence systemic inflammation, immune activation, and neurological regulation. Please indicate if any apply.

☐ Amalgam fillings ☐ Root canals ☐ Gum disease ☐ Dental infections ☐ Recent dental procedure

Major illnesses or surgeries:

HEALTH GOALS

What are your goals for your child's health over the next 6–12 months?

On a scale of 1–10, how ready are you to actively support changes to improve your child's long-term health? 1 2 3 4 5 6 7 8 9 10

PARENT / GUARDIAN AGREEMENT

I certify that the information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____

Records Release

AUTHORIZATION TO RELEASE X-RAYS & INFORMATION

To:_____

I,_____ Birth date _____/_____/_____

request the following information:

□ X-RAYS □ History □ Records

□ Diagnosis □ Reports □ Prior Care Details

concerning my: □ Illness □ Accident □ Injury

Other:_____

Signature:_____

Date_____

□ Patient □ Parent □ Spouse □ Guardian

HIPAA Policies

Health Insurance Portability and Accountability Act

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

During the course of your care, we may use, or disclose, health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another healthcare provider if a referral is necessary for care, diagnosis, or assessment.
- Your healthcare and/or billing records may be disclosed to another party, such as an insurance carrier or your employer, if they are responsible for payment of services.
- Your personal information and/or healthcare records may be used to contact you regarding appointments or other health-related information that may be of interest to you.

At your request, we may restrict the use of your protected health information for patient-care or payment purposes. Such requests are not automatic and require our acknowledgement prior to initiation.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to
such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted, and may be required, to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- By order of the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

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 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.

We normally provide information about your health to you in-person at the time you receive care. 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 in a specific form, you may advise us in writing.

You have the right to inspect, copy, or request an amendment of your health information for as long as the information remains in our files. These requests to inspect, copy or amend your health information shall be in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected 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 inwriting following the changes. Any change in our privacy notice will apply for all of your health information in our files.
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:

Cory Singer DC

If you would like further information about our privacy policies and practices please contact:

Cory Singer DC

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or by our staff in any manner whatsoever.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Patient Name (please print) Signature Date

If you are a minor or if you are being represented by another party:

Case Types

Consultations: No Charge
Physical Examinations: $85 to $175
Office Visits: $35 to $95
X-ray studies: $44 to $152
Extended Consultations: $85
Thermograph: $165

(All fees are standard and primarily based on our professional association's guidelines.)

Our experience has shown that it is important to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment, and you may choose the plan which best fits your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please let us know. Our main concern is your health and well-being, and we will do our best to help you.

All first visit charges are payable when services are rendered.

The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Case #1 – General Health Insurance: If you have insurance that covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance card on or before your second visit. Until we have the completed, necessary insurance information to verify Chiropractic coverage, you will be required to pay for your care. After we verify your insurance company's benefit details, we will discuss them with you. Most insurance companies will not cover "maintenance" care and therefore, we can offer other arrangements if your condition requires further care beyond your insurance limits.

Case #2 – Private Pay / Cash: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

Case #3 – Industrial (Work-Related) Injury: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

Case #4 Auto Injury: You need to supply us with the accident report, your car insurance, health insurance, liable party's insurance, and attorney information (if applicable). Until necessary insurance information is gathered and benefits verified, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

I QUALIFY FOR, AND UNDERSTAND, PLAN #_____ REQUIREMENTS.

_____ Please note that any nutritional supplements or lab work ordered cannot be billed
(initial) through our office for insurance reimbursement and fall under private pay/cash case type #2

SIGNATURE: _____ DATE: _____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:

> “Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Name_____

Signature_____ Date_____

SINGER CHIROPRACTIC WELLNESS CENTER

MEDIA AUTHORIZATION & MISSION RELEASE

OUR MISSION

Our mission is to help people heal naturally by restoring function across the body, brain, and biochemistry, and empowering people to understand and care for their health.

Education is central to this mission. By sharing real patient experiences and clinical insights, we help others better understand how the body works and what is possible when underlying causes are properly addressed.

EDUCATIONAL MEDIA IN THE OFFICE

As part of fulfilling our mission, Singer Chiropractic Wellness Center may create educational media within the office environment. This may include photographs, audio recordings, or video recordings captured during visits, consultations, examinations, or chiropractic adjustments.

Media may be used for:

- Patient education
- Website and social media content
- Educational presentations or seminars
- Marketing and promotional materials aligned with our mission

These recordings are created to educate, inspire, and empower others to take ownership of their health.

By choosing to participate, you are helping others gain clarity, hope, and direction. Many people delay care because they do not understand what is possible. Your story may be the permission someone else needs to begin their healing journey.

MEDIA AUTHORIZATION & RELEASE

By signing below, I voluntarily authorize Singer Chiropractic Wellness Center, its representatives, employees, contractors, and assigns to photograph, record, and/or use my name, voice, image, likeness, and written or spoken statements for educational and promotional purposes consistent with the mission of the practice.

I understand that:

1. Participation is voluntary.
2. I will not receive financial compensation for the use of these materials.
3. My participation may disclose that I am a patient of Singer Chiropractic Wellness Center.
4. No private medical records or protected health information will be disclosed without separate written authorization.
5. Once content is published, it may be publicly accessible and may not be fully retractable.
6. I may revoke this authorization at any time in writing; however, revocation does not apply to materials already created or published prior to written revocation.

I release and discharge Singer Chiropractic Wellness Center from any claims arising from the authorized use of such media, including claims for invasion of privacy, defamation, or violation of right of publicity under California Civil Code §3344.

CONSENT & LIMITATIONS

Unless I specifically limit or revoke consent in writing below, this authorization applies to all media uses described above.

If you would like to limit your consent, please describe any restrictions here (optional):

_____

_____

If you prefer not to authorize any media use, you may decline to sign this form.

Printed Name: _____

Signature: _____

Date: _____

If patient is a minor:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Arbitration Agreement and Informed Consent

PATIENT NAME:_____

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 3

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those wor1dng at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here:_____ ; Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____ _____

PATIENT SIGNATURE Date (Indicate relationship if signing for patient)

(Or Patient Representative

Arbitration Agreement and Informed Consent

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, Including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discus with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to the treatment, including but not limited to, fracture, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
PATIENT SIGNATURE	Date	(Indicate relationship if signing for patient)
_____	_____	
OFFICE SIGNATURE	Date	