New Life Chiropractic LLC.

Confidential Health Report - Infant to 5 years old

Personal Information			
Child's Name		Preferred/Nickname	
Parent(s)/Guardian(s) Name			
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Child's SSN	Birth Date	Age	Gender: M / F
Have you or your child ever had chiropractic care before? ☐ yes ☐ no			
If yes, please tell us the chiropractor's name:			
How did you find out about out office?			
Is this appointment related to an auto accident? ☐ yes ☐ no			
If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire			
Is your child receiving care from other health professionals? ☐ yes ☐ no			
If yes, please name them and their specialty?			
Who is your family's primary care physician?			
Please list any drugs or medications your child is taking			
Please list any reactions your child has had to medications			
Please list and vitamins/herbs/homeopathic/other supplements your child is taking			
Please list any allergies your child has			

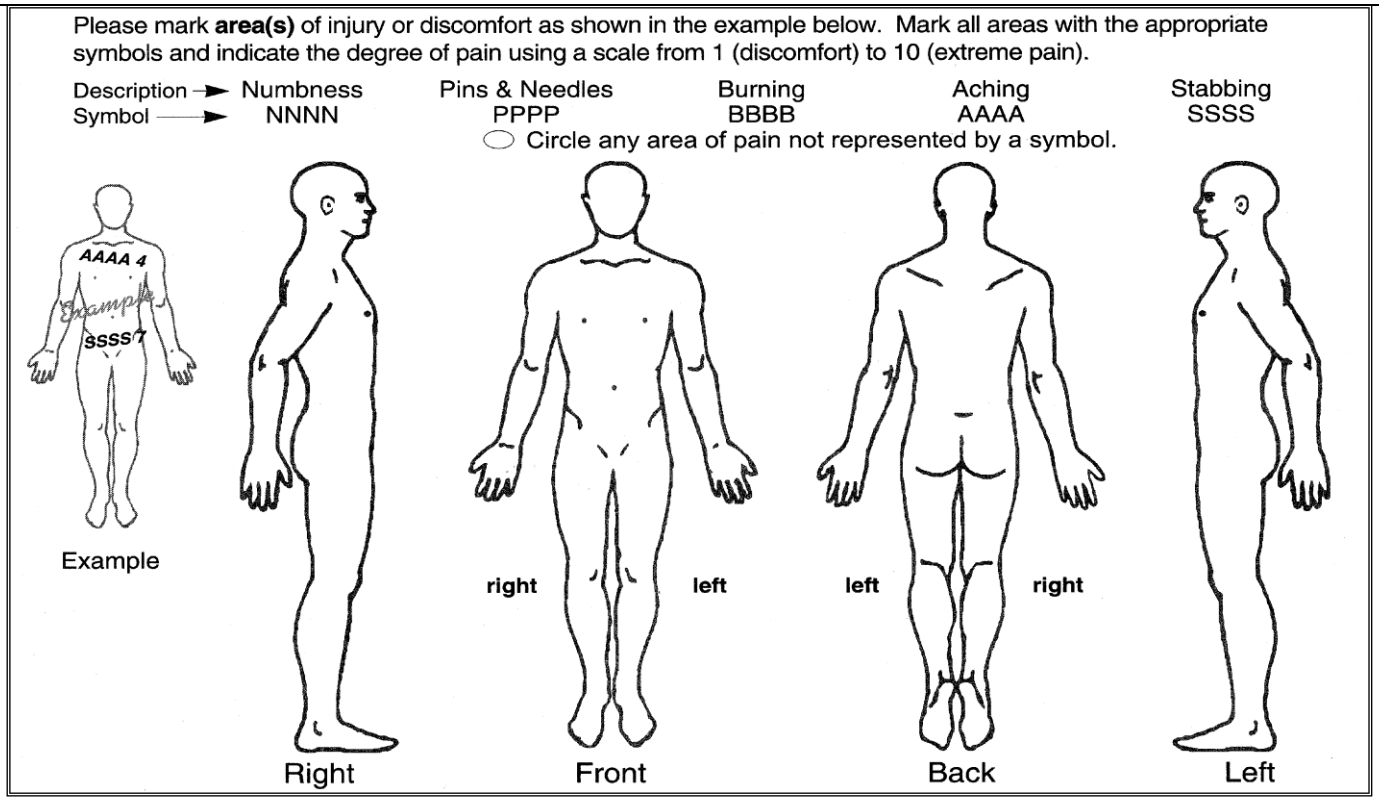
Health History			
Child's birth was ☐ At home ☐ At a birthing center ☐ At a hospital			
My obstetrician/midwife/family physician was			
Child's birth was ☐ Natural vaginal (no medications/interventions) ☐ Vaginal with interventions ☐ Induction ☐ Pain medications ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other _____ ☐ C-section ☐ Scheduled ☐ Emergency			
Please list reasons for any interventions/complications			
Child's birth weight	birth height	current weight	current height
APGAR score at birth	APGAR score after 4 minutes		

Please list any conditions child's parents and siblings suffer from
What is the cause and age of deaths of child's parents and siblings?

Growth & Development
Was your child alert and responsive within 12 hours of delivery? ☐ yes ☐ no
If no, please explain
At what age did your child Respond to sound _____ Follow an object _____ Hold head up_____ Vocalize_____ Sit alone_____ Teethe_____ Crawl_____ Walk_____ Potty-train _____
Any milestones that your child had difficulty with? ☐ yes ☐ no
If yes, please explain
Patient/Hospitalizations/Surgical History (please list below all surgery & hospitalizations, including year)
Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year
Is/was your child breastfed? ☐ yes ☐ no If yes, how long?
Formula introduced at what age? What type?
Introduction to cow's milk at what age? Began solid foods at what age?
Please list any foods/juice intolerance
Did mother smoke during pregnancy? ☐ yes ☐ no
Did mother drink alcohol during pregnancy? ☐ yes ☐ no
Any illness of mother during pregnancy? ☐ yes ☐ no
If yes, please explain including treatment/medications/supplements
List any drugs/medications (including over the counter) taken during pregnancy
List any supplements taken during pregnancy
Any ultrasounds performed during pregnancy? ☐ yes ☐ no If so, how many & medical reason?
Any pets at home? ☐ yes ☐ no Any smokers at home? ☐ yes ☐ no
Has child received any antibiotics? ☐ yes ☐ no
If yes, how many times and list reason
Any difficulty breastfeeding? ☐ yes ☐ no
If yes, please explain
Did child prefer to breastfeed on one side? ☐ yes ☐ no If yes, please explain
Age child began daycare_____

Current Health

Complete diagram IF complaint is pain-based



Are there any health concerns that bring your child to our office or is this a wellness visit?
If your child is experiencing symptoms, when did the symptoms first begin?
How did the problem start? ☐ Suddenly ☐Gradually ☐ Post-Injury
If Post-Injury, please explain
Is this concern ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Not Sure
What makes the problem better?
What makes the problem worse?
Has your child ever had a similar condition? ☐ yes ☐ no
Please explain
Has your child been treated for this condition before? ☐ yes ☐ no
Please explain

CHECK THE FOLLOWING CONDITIONS YOUR CHILD HAS HAD:

____ Appendicitis	____ Measles	____ Scarlet Fever	____ Venereal Disease
____ Chicken Pox	____ Mononucleosis	____ Sinus Infections	____ Whooping Cough
____ Cold Sores	____ Mumps	____ Tonsillitis	___ Other _____
____ Croup	____ Polio	____ Tuberculosis	_____
____ Diphtheria	____ Rheumatic Fever	____ Typhoid Fever	

CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOUR CHILD HAS **NOW (N)** OR THE **PAST (P)**:

N	P	*GENERAL:*
____	____	Autoimmune
____	____	Cancer ...if so, what type:_____
____	____	Excessive crying
____	____	Difficulty crawling or walking
____	____	Dyslexia
____	____	Failure to Thrive
____	____	Frequent Colds/Flus
____	____	Headaches
____	____	Increased/Decreased Appetite
____	____	Migraines
____	____	Loss of Sleep or Increased Sleep
____	____	Loss of Weight or Increased Weight
____	____	Tremors or Shaking
____	____	Scoliosis
		BEHAVIORAL
____	____	Abuse/Neglect
____	____	Addiction
____	____	Anxiety
____	____	Arching/Flailing
____	____	Autism spectrum
____	____	Depression
____	____	Difficulty Bonding
____	____	Eating Disorder
____	____	Hyperactivity
____	____	Night terrors/sleepwalking
		CARDIOVASCULAR:
____	____	Arrhythmia
____	____	Anemia/Iron Deficiency
____	____	Arteriosclerosis
____	____	Cold Hand/Feet
____	____	Heart Surgery/Pacemaker
____	____	Heart Disease
____	____	High Blood Pressure
____	____	Low Blood Pressure
____	____	Rapid/Slow Beating Heart
____	____	Stroke
____	____	Valve or Heart Disorders
____	____	Other heart condition _____
		E.E.N.T.:
____	____	Deafness/Difficulty Hearing
____	____	Dizziness/ Vertigo
____	____	Ear Infections
____	____	Hay Fever/Seasonal Allergies
____	____	Hoarseness
____	____	Nosebleeds
____	____	Sore Throat

N	P	*GASTRO-INTESTINAL*:
____	____	Acid Reflux/Difficult Digestion
____	____	Belching/Gas
____	____	Colic
____	____	Constipation
____	____	Diarrhea
____	____	Gall Bladder Attacks/Irritation
____	____	Hernia
____	____	Jaundice
____	____	Liver Conditions
____	____	Ulcer/Colitis
		ENDOCRINOLOGY
____	____	Diabetes
____	____	Hypoglycemia
____	____	Thyroid deficiency/Goiter
____	____	Osteopenia/Osteoporosis
		NEUROLOGICAL
____	____	Epilepsy/Seizures
____	____	Fibromyalgia
____	____	Multiple Sclerosis
		RESPIRATORY:
____	____	Asthma
____	____	Bronchitis
____	____	Chest Pain
____	____	Chronic Cough
____	____	Difficulty Breathing
____	____	Emphysema
____	____	Pleurisy
____	____	Pneumonia
____	____	Wheezing
		GENITO-URINARY:
____	____	Bed Wetting
____	____	Blood/Pus in Urine
____	____	Frequent Urination
____	____	Inability to Control Urine
____	____	Painful Urination
		SKIN:
____	____	Acne
____	____	Bruise Easily
____	____	Hives or Allergy
____	____	Itching or Rashes
____	____	Eczema
____	____	Psoriasis
____	____	Other skin condition _____

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Pediatric Health Questionnaire

Name:		Age:		Date:	

Please circle the best answer for each statement beginning with "My child…" or "My child's…"

SECTION 1 – Pain Intensity

A. has no pain at the moment.
B. pain is very mild at the moment.
C. pain is moderate at the moment.
D. pain is fairly severe at the moment.
E. pain is very severe at the moment.
F. pain is the worst imaginable at the moment.

SECTION 2 – Fever

A. has no fevers at all.
B. has slight fevers which come infrequently.
C. has moderate fevers which come infrequently.
D. has moderate fevers which come frequently.
E. has severe fevers which come frequently.
F. has fevers almost all the time.

SECTION 3 – Earaches

A. has no earaches at all.
B. has slight earaches which come infrequently.
C. has moderate earaches which come infrequently.
D. has moderate earaches which come frequently.
E. has severe earaches which come frequently.

SECTION 4 – Headaches

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

SECTION 5 – Digestion

A. has no trouble eating at all.
B. has slight trouble eating which come infrequently.
C. has moderate trouble eating which come infrequently.
D. has moderate trouble eating which come frequently.
E. has severe trouble eating which come frequently.
F. has trouble eating almost all the time.

SECTION 6- Bowel/Bladder

A. has no b/b issues at all.
B. has slight b/b issues which come infrequently.
C. has moderate b/b issues which come infrequently.
D. has moderate b/b issues which come frequently.
E. has severe b/b issues which come frequently.
F. has b/b issues almost all the time.

SECTION 7 – Skin

A. has no skin issues at all.
B. has slight skin issues which come infrequently.
C. has moderate skin issues which come infrequently.
D. has moderate skin issues which come frequently.
E. has severe skin issues which come frequently.
F. has skin issues almost all the time.

SECTION 8 – Play

A. can play as they want to.
B. can only play their usual.
C. can play most of their usual.
D. cannot play like usual.
E. can hardly play at all.

SECTION 9 – Sleeping

A. has no trouble sleeping.
B. sleep is slightly disturbed (less than 20% sleepless).
C. sleep is mildly disturbed (40% sleepless).
D. sleep is moderately disturbed (60% sleepless).
E. sleep is greatly disturbed (80% sleepless).
F. sleep is completely disturbed (100% sleepless).

Section 10 - Changing Health

A. health is rapidly getting better.
B. health fluctuates, but overall is definitely getting better.
C. health seems to be getting better, slowly.
D. health is neither getting better nor worse.
E. health is gradually worsening.
F. health is rapidly worsening.

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CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Devin to administer chiropractic care as he/she deems necessary to my _____.
Relationship to Minor

_____
Name of Minor

_____
Signature of Parent/Guardian Date

Parent/Guardian Information

Mothers Name: _____

Address: _____

Home Ph: _____ Cell Ph: _____

SSN: _____ Date of Birth: _____

Employer Name, Address, Phone _____
_____

Fathers Name: _____

Address: _____

Home Ph: _____ Cell Ph: _____

SSN: _____ Date of Birth: _____

Employer Name, Address, Phone: _____
_____

Are there any other guardians or adults that will be at appointments? Y / N
If yes, are they allowed to receive information regarding the minor? Y / N
Please list the name(s) of any other individual(s) and relationship to the minor:
_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social wellbeing, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature Relationship to Patient Date

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Relationship to Patient Date

INSURANCE

Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. I have been notified by my physician that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. All payment is due at the time of service.

Signature Relationship to Patient Date

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. King will assist in preparing any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Relationship to Patient Date