PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____ Child's SS #: _____

Child's Home Phone #: _____

Child's Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Mother's Name: _____ Father's name: _____

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

Parent's Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

List Ages of Other Children in Family: _____

Predominant language used at home: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relative to the person who is responsible for the child's health insurance coverage.

Insured's Name: _____ Birth date: _____ SS #: _____

Insurance Company Name: _____ Phone No: _____

Insurance Company Address to send claims: _____

Employer: _____ Group No: _____ Insured's ID #: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree the I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____ Signature _____

Date: _____ Witnessed by: _____

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PREGNANCY HISTORY

Today's Date _____

Child's Name _____ Sex: M F Date of Birth: _____ Age ___ __

Mother's Name: _____ How many children do you have? _____

What was the term of your pregnancy? ___ ___ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA	☐	☐	_____
High B.P?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning sickness?	☐	☐	_____
Indigestion?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen ankles?	☐	☐	_____
Thyroid problems?	☐	☐	_____
Heart problems?	☐	☐	_____
Back pain?	☐	☐	_____
Abnormal bleeding?	☐	☐	_____
Were you hospitalized?	☐	☐	_____
Any other Illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication _____ Reason _____
Over-the-counter meds?	☐	☐	Medication _____ Reason _____

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NEWBORN HISTORY

Birth to 2 months

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During day _____ At night _____

Yes ☐ No ☐ Does your baby go to sleep easily? _____

Yes ☐ No ☐ Does baby have a preferred sleeping position? _____

Yes ☐ No ☐ Does baby cry if you change this sleeping position? _____

Yes ☐ No ☐ Does baby have any feeding difficulties? _____

Yes ☐ No ☐ Is baby being breast fed? If no, for how long was baby breast fed _____ weeks/mths

Yes ☐ No ☐ Does baby have a one sided breast-feeding preference? Preferred breast Left / Right

Yes ☐ No ☐ Is baby formula fed? Which formula or other milk source? _____

Yes ☐ No ☐ Does baby frequently spit-up after feeding? _____

Yes ☐ No ☐ Does your baby cry a lot? For how many hours each day? _____

Yes ☐ No ☐ Does baby pass a lot of intestinal gas? _____

Yes ☐ No ☐ Does baby have a preferred head position? _____

Yes ☐ No ☐ Does baby frequently arch his/her head and neck backwards? _____

Yes ☐ No ☐ Does baby cry or become irritable during a diaper change? _____

Yes ☐ No ☐ Has baby ever had a fever? _____

Yes ☐ No ☐ Has baby had any falls? _____

Yes ☐ No ☐ Has baby been in a car accident or near-miss? _____

Yes ☐ No ☐ Has baby had any other trauma? _____

Yes ☐ No ☐ Has your baby been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns you wish to discuss? _____

_____

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BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

	Yes	No	
Hospital birth	☐	☐	_____
Home birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	_____
Emergency C-section	☐	☐	_____
Was Birth Induced (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____
Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute _____ / 10 At 5 minutes _____ / 10

Baby's Crying Baby Cried Immediately After Birth ☐ ☐

Cried Strongly _____ Weak Cry _____ Did Not Cry for _____ minutes

Baby's Color Pink all over _____ Blue face _____ Blue Hands/Feet _____

Baby's activity Arms and legs actively moving _____ Floppy baby _____

Intensive Care Was required _____ Days in Neonatal Intensive Care Unit _____

Medication given at birth? _____ _____ Vaccines Administered _____

Birth weight _____ lbs / kgs Birth length _____ ins / cms Baby home on day _____

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INFANT HISTORY

2 months to 2 years

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age ___

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION

Yes No

☐ ☐ Is your child still being breast fed? If no, for how long was he/she breast fed _____

If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes No

☐ ☐ Is your child formula fed? Which formula or other milk source? _____

Yes No

☐ ☐ Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Yes No

☐ ☐ Does your child have any feeding difficulties? _____

Yes No

☐ ☐ Does your child have any digestive disturbances? _____

Yes No

☐ ☐ Does your child have any food allergies? _____

Yes No

☐ ☐ Does your child have any persistent or intermittent skin rashes? _____

Yes No

☐ ☐ Is your child receiving any vitamin supplements? _____

TRAUMA

Yes No

☐ ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred? _____

Yes No

☐ ☐ Has your child ever fallen down stairs or fallen from any height? _____

Yes No

☐ ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

Yes No

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

Yes No

☐ ☐ Has your child had any other trauma or injuries? _____

Yes No

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

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INFANT HISTORY

2 months to 2 years

GROWTH AND DEVELOPMENT

Yes ☐ No ☐ Can your child sit unsupported? At what age did your child start to sit-up? _____ mths

Yes ☐ No ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

Yes ☐ No ☐ Is your child walking yet? At what age did your child start to walk? _____ mths

Yes ☐ No ☐ Does your child often trip and fall? _____

Yes ☐ No ☐ Does your have any other concerns about your child's growth and development? _____

HEALTH HISTORY

Yes ☐ No ☐ Has your child had colic? _____

Yes ☐ No ☐ Has your child had any upper respiratory infections? How often? _____

Yes ☐ No ☐ Has your child had asthma? _____

Yes ☐ No ☐ Does your child ever complain of back or neck pain? _____

Yes ☐ No ☐ Does your child ever complain of pains in the arms or legs? _____

Yes ☐ No ☐ Does your child ever complain of headaches? _____

Yes ☐ No ☐ Has your child had any earaches ? At what age did the first earache occur _____

Yes ☐ No ☐ How frequently does your child have earaches? _____

Yes ☐ No ☐ Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? ___

Yes ☐ No ☐ Has your child had any other illnesses?
Please list each illness and its approximate date _____

_____

Yes ☐ No ☐ Is your child presently receiving any medications ? _____

Yes ☐ No ☐ Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes ☐ No ☐ Has your child recently been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns about your child's health? _____

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PRE-SCHOOL CHILD HISTORY

3 years to 5 years

Today's Date _____

Child's Name _____ Sex: M F Date of Birth _____

Age _____

Reason for Today's Visit _____

Yes ☐ No ☐ Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was onset Sudden ☐ or Gradual ☐ Is problem Constant ☐ or Intermittent ☐

Yes ☐ No ☐ Has your child ever had this problem before? _____

Yes ☐ No ☐ Has your child previously been treated for this problem? By whom? _____

Yes ☐ No ☐ Has your child previously had chiropractic care? Previous chiropractor _____

HEALTH HISTORY

Yes ☐ No ☐ Does your child ever complain of back or neck pain? _____

Yes ☐ No ☐ Does your child ever complain of pains in the legs or arms? _____

Yes ☐ No ☐ Does your child ever complain of headaches? _____

Yes ☐ No ☐ Has your child had asthma? _____

Yes ☐ No ☐ Is your child allergic to anything? _____

Yes ☐ No ☐ Are there any smokers in the child's home? _____

Yes ☐ No ☐ Has your child had any earaches ? At what age did the child's first earache occur _____

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? Right ☐ Left ☐ Both ☐

Yes ☐ No ☐ Is your child presently taking any prescribed medication ? _____

Please list any other illness which have been a concern for your child

_____

Please list any surgeries your child has had

_____

Yes ☐ No ☐ Do you have any other concerns about your child's health? _____

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PRE-SCHOOL CHILD HISTORY

3 years to 5 years

TRAUMA

Yes ☐ No ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred _____

Yes ☐ No ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____

Yes ☐ No ☐ Has your child ever fallen down stairs or fallen from a significant height? _____

Yes ☐ No ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

Yes ☐ No ☐ Has your child ever had a bone fracture or joint dislocation? _____

Yes ☐ No ☐ Has your child had any other trauma or injuries? _____

Yes ☐ No ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

NUTRITION

Yes ☐ No ☐ Do you have any concerns about your child's diet? _____

Yes ☐ No ☐ Does your child have any food allergies? _____

Yes ☐ No ☐ Does your child have any persistent or intermittently occuring skin rashes? _____

Yes ☐ No ☐ Does your child take vitamin supplements? _____

Yes ☐ No ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for Breakfast? _____

What does your child usually eat for Lunch? _____

What does your child usually eat for Dinner? _____

What does your child usually eat for Snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of fast foods does your child like to eat? _____

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RESULTS CHIROPRACTIC
A Family Wellness Center
John S. Urban III D.C.

Minor Consent Form

_____ has my permission to be treated without parental presence.

_____ _____
Signature (Parent or Guardian) Date

_____ _____
Witness Date

Results Chiropractic Inc.

A Family Wellness Center

Terms of Acceptance/Informed Consent

When we accept you as a patient into our practice, it is important that you understand the objectives of our care.

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress in your body.)

A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause dis-ease or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxations by using specialized techniques (spinal adjustment.) When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural healing ability, your inner healer, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptoms(s) your body is expressing, you always need a body free from subluxations.

If, during the course of our chiropractic spinal examination, we encounter unusual findings, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them in your goals.

To summarize: the purpose of chiropractic care is not to treat the diseases or conditions, not to suppress symptoms, nor to perform surgery, but rather to make your body function better by removing spinal nerve stress (subluxations). Therefore we don not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

Our objective is to eliminate a major interference to the expression of your physical/emotional health and healing-vertebral subluxations – so that your natural healing ability and your inner healer may function without this severe form of stress.

Signature_____ Date_____

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Our objective is to eliminate a major interference to the expression of your physical/emotional health and healing vertebral subluxations so that your natural healing ability and your inner healer may function without this severe form of stress.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between the provider and patient.

I authorize the performance of any necessary diagnostic tests and treatments, which usually include chiropractic manipulation (CMT) for my condition(s). Like most health care procedures, CMT carries with it some risks. Unlike other medical treatments, the serious risks associated with CMT are extremely rate. Included are soreness or initial increased pain symptoms. More rare is dizziness, nausea or flushing, susceptibility of fracture with conditions like osteoporosis. Herniated or bulged discs may worsen even with CMT---it is important to notify the doctor of changes in symptoms. Extremely rare is a risk of a certain type of stroke, although this risk is the same with primary medical care and is associated with the nature of neck pain and headache presented by the patient.

Notice to Medicare Patients

Relative Contraindications: Do you have any of the following conditions?

☐ Joint Hypermobility, ☐ Osteoporosis/Osteopenia, ☐ Benign Bone Tumors, ☐ Bleeding Disorders, ☐ Blood Thinners, ☐ Progressive Radiculopathy

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust may be contraindicated in your condition. By signing below, you consent to care and agree to inform this office if another healthcare provider tells you that you have one of these conditions.

Absolute Contraindications of given area: Do you have any of the following conditions?

☐ Rheumatoid Arthritis, ☐ Spinal Cancer, ☐ Ankylosing Spondylitis, ☐ Ligament Laxity, ☐ Joint Dislocation, ☐ Recent/Unstable Joints, ☐ Unstable/Missing Dens at C2, ☐ Spinal/Joint Infection, ☐ Myelopathy/Cauda Equina Syndrome, ☐ Vertebrobasilar Insufficiency Syndrome, ☐ Arterial Aneurysm

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust is absolutely contraindicated in the region of the spine that is affected. By signing below, you agree to inform this office if another healthcare provider tells you that you have one of these conditions.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: _____ Date: _____