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Chiropractic Orthospinologists

PEDIATRIC DETAILED INFORMATION

Child's name: _____ Birth date: ___/___/___ Age:_____ Sex: _____
Birth weight: _____ Birth length: _____ Current weight: _____ Current length: _____
Number of siblings: _____ Referred by: _____

Mother's name: _____ DOB: ___/___/___
Mother's work phone: _____ Mother's cell phone: _____
Fathers name: _____ DOB: ___/___/___
Father's work phone: _____ Father's cell phone: _____
Address: _____ City/Town: _____
State:_____ Zip:_____

Third trimester presentation/ position:
☐Vertex/Head-down ☐Breech/Rear-down ☐Transverse/Side-lying ☐ Face/Brow
Type of birth: ☐Normal / Vaginal ☐Forceps ☐Cesarean or Vacuum
Location: ☐Home ☐ Birthing Center ☐Hospital: _____
Problems during pregnancy: _____
Problems during labor / delivery:_____
Was the child born premature? _____ If so, how early? _____
Did the mother suffer any falls/accidents during pregnancy? _____
APGAR Score: ____ - ____ Was there presence at birth of: ☐Jaundice (Yellow) ☐Cyanosis (Blue)
Congenital anomalies / defects? _____ If yes, please explain: _____

Infant feeding: ☐Breast ☐Bottle If bottle, which formula?_____
Number of hours sleeping per night:_____ Quality of sleeping: ☐Good ☐Fair ☐Poor

Obstetrician / Midwife: _____
Pediatrician / Family Dr.: _____
Date of last visit: ___/___/___ Purpose: _____
Immunization History: _____
Any adverse reactions? _____ If yes, please explain: _____
Number of doses of antibiotics your child has taken during:
The past 6 months: _____ During their lifetime:_____
Previous Chiropractor: _____
Date of last visit: ___/___/___ Purpose: _____
Has your Child ever been treated on an emergency basis? Explain: _____
_____

Purpose of this appointment: _____

_____

Delivery / Birth History: _____

_____

_____

At what age did the child:

Respond to sound: _____ Follow an object with his/ her eyes: _____ Hold head up: _____

Sit alone: _____ Crawl: _____ Stand: _____ Walk alone: _____

At what age, if ever, did this child suffer from the following childhood diseases:

Chickenpox: _____ Mumps: _____ Measles: _____ Rubella: _____

Rubeola: _____ Whooping cough: _____ Other: _____

Has the child ever suffered from (check all that apply):			
☐ Headaches ☐ Dizziness ☐ Fainting ☐ Seizures/Convulsions ☐ Heart trouble ☐ Chronic earaches ☐ Sinus trouble ☐ Asthma ☐ Colds / Flu ☐ Colic	☐ Orthopedic Problems ☐ Neck Problems ☐ Arm Problems ☐ Leg Problems ☐ Joint Problems ☐ Backaches ☐ Poor Posture ☐ Scoliosis ☐ Walking Trouble ☐ Broken Bones	☐ Digestive Problems ☐ Poor Appetite ☐ Stomach Aches ☐ Reflux ☐ Constipation ☐ Diarrhea ☐ Diabetes ☐ Hypertension ☐ Anemia ☐ Bed Wetting	☐ Behavioral Problems ☐ ADD / ADHD ☐ Ruptures / Hernia ☐ Muscle Pain ☐ Growing Pain ☐ Allergies

Has the child ever suffered the following spinal traumas? (check all that apply)		
☐ Fall in baby walker ☐ Fall from crib ☐ Fall from highchair ☐ Fall from changing table	☐ Fall from bed or couch ☐ Fall off swing ☐ Fall off slide ☐ Fall off monkey bars	☐ Fall off skateboard or skates ☐ Fall off bicycle ☐ Fall down stairs ☐ Other:_____

Has the child ever sustained an injury playing organized sports? _____ If yes, please explain: _____

_____

Has the child ever sustained injuries in an auto accident? _____ If yes, please explain: _____

_____

Recent History: _____

_____

_____

Hospitalization / Surgeries: _____

Medications: _____

Accidents: _____

Family History (check all that apply and indicate relative):	
☐ Diabetes:	☐ Neurological:
☐ Heart, Vascular, Circulation:	☐ Psychiatric:
☐ Kidney:	☐ Cancer:
☐ Gastrointestinal:	☐ Respiratory:
☐ Respiratory:	☐ Autoimmune:
☐ Musculoskeletal:	☐ Other:

I hereby authorize this office and its doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).
I understand that it is my responsibility to notify the doctor if any of the information has changed or requires updating.

Parent / Guardian Name (Print): _____

Signed: _____ Witness: _____ Date: ___/___/___

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.
X-rays remain property of this office.

Signed: _____ Date: ___/___/___

HEALTH CARE AUTHORIZATION

As of April 14, 2003, the Federal Government requires a patient's signature to authorize being contacted by phone, mail, etc. This is a result of the Health Insurance Portability Act (HIPAA). The goal is to protect your personal health information.

PRINT PATIENT NAME

Last **First** **Middle Date of**

Birth _____/_____/ _____

Specific Authorizations:
I give permission for the Humber Clinic to contact me by e-mail, phone or leave message on my voice-mail regarding my appointments and status of health. I also give permission to use my name and address to mail office and e-mail newsletters, referral cards, postcards, holiday related cards or information about health related issues.

Initial Here: _____

Patient Rights:

1. **You have the right to refuse to sign this authorization.** If you refuse to sign this Authorization, the Humber Chiropractic Clinic will not refuse to provide treatment.

2. **You have the right to revoke this authorization, in writing at any time.** You may revoke this Authorization by mailing or hand delivering a written notice to the Privacy Official of the Humber Chiropractic Clinic. The written notice should contain your name, Social Security number and date of birth. State your intent to revoke this authorization, then sign and date it. Once received, the Privacy Official will revoke the authorization.

3. **You have the right to a copy of this authorization.**

Patient Signature_____**Date:** _____

Personal Representative Signature (if applicable):

_____

For Office Use Only
Expiration -
This Authorization shall expire in 7 years. Expiration Date:

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic's procedure often depends on underlying causes, patient compliance, as well as other spinal and physical conditions.

ADJUSTMENTS
The doctor utilizes the Grostic/Orthospinology Procedure, which is a low-force, non-rotary upper cervical (neck) technique. If adjustments to the lower spine are required, then the doctor will usually utilize a low-force, non-rotary adjustments, drop table, or handheld instrument.

INFORMED CONSENT FOR CHIROPRACTIC CARE
As a patient, you agree to give the doctor permission and authority to care for you in accordance with the chiropractic tests and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects of pathologies may render a patient susceptible to injury. The doctor will not provide healthcare if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS
As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from you care. Chiropractic care is not a treatment of disease, but a system of correcting vertebral subluxations. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedure is superior to his fellow chiropractors.

AUTHORIZATION
In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or other healthcare professionals for the sake of case management. As a patient, you are giving the doctor permission to use his best judgement for when to allow an observer in the room or when it is necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT
Please discuss any question or problems with the doctor before signing this statement of policy. I have had the above explained to me and after reading it, I understand the foregoing and give my consent. I acknowledge that the doctor reserves the right to discontinue and/or refuse care in the event that it becomes unsafe to render care or I become noncompliant with the current care plan.

Signature:_____ Date: _____