

SNOHOMISH FAMILY CHIROPRACTIC
PEDIATRIC NEW PATIENT INFORMATION - NEW BORN

Date: _____

PATIENT INFORMATION:

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

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____

Home Phone#: _____ Cell Phone#: _____

Child's Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Parent 1: _____ Parent 2: _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

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

List Age of Other Children in Family: _____

Predominant language used at home: _____

Email Address: _____

CONSENT TO TREAT

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

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

Parent's Name: _____ Signature: _____

Date: _____

PREGNANCY HISTORY

DURING YOUR PREGNANCY, DI 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?	_____	_____	_____
Had DTAP Vaccine?	_____	_____	_____
Had Flu Shot?	_____	_____	_____
How Many Ultrasounds?	_____	_____	_____

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

	Yes	No	
Tobacco?	_____	_____	_____
Alcohol?	_____	_____	_____
Prescription Drugs?	_____	_____	_____
Over-The-Counter Meds?	_____	_____	_____
Recreational Drugs?	_____	_____	_____

What was the term of your pregnancy? _____ Weeks

BIRTH HISTORY

LABOR AND DELIVERY

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

How long was 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 Extraction	_____	_____	_____
Vacuum Extraction	_____	_____	_____
Anesthesia Administered	_____	_____	_____
Fetal Distress	_____	_____	_____
Meconium Staining	_____	_____	_____
Cord Wrapped Around Neck	_____	_____	_____
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 __ Didn't Cry for __ Mins.

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./kg Birth Length _____ ins/cms Baby Home on Day ____

NEWBORN HISTORY

Birth to 2 Months

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?	___	___	_____
Does your baby have a preferred sleeping position?	___	___	_____
Does baby cry if you change the sleeping position?	___	___	_____
Does baby have any feeding difficulties?	___	___	_____
Is baby being breast fed? (if No for how long)	___	___	_____
Does baby have a one-sided breast-feeding preference?	___	___	_____
Is baby formula fed? (Which formula or other milk source)	___	___	_____
Does baby frequently spit-up after feeding?	___	___	_____
Does baby cry a lot? For how many hours each day?	___	___	_____
Does baby pass a lot intestinal gas?	___	___	_____
Does baby have a preferred head position?	___	___	_____
Does baby frequently arch his/ her head & neck backwards?	___	___	_____
Does baby cry or become irritable during diaper change?	___	___	_____
Has baby ever had a fever?	___	___	_____
Has baby had any falls?	___	___	_____
Has baby been in a car accident or near miss?	___	___	_____
Has baby had any other trauma?	___	___	_____
Has your baby been vaccinated?	___	___	_____
Do you have any concerns you wish to discuss?	___	___	_____



INFORMED CONSENT
Snohomish Family Chiropractic

Patient: _____

Chiropractic is the science of locating and reviewing inference with the transmission or expression of nerve force in the human body, by the correction of misalignments or subluxations of the bony articulations and adjacent structures more especially those of the vertebra column and pelvis, for the purpose of restoring and maintaining health. Chiropractic recognizes that essentially only the body heals and therefore holds forth no cure for disease and does not guarantee any specific result. The primary chiropractic examination finding is the Vertebral Subluxation and the primary chiropractic procedure is the chiropractic adjustment, performed manually and / or with a manual device.

The material risks inherent in the chiropractic adjustment and examination: There are potential complications with any health care procedure. The most common side effect is stiffness and soreness and moving of symptoms during the first few weeks of care. Bruising can occur. Rare complications include fractures disc injuries, dislocations, paralysis, strains and sprains. Some techniques used to manipulate the cervical spine (neck region) have been implicated in injury to the arteries in the neck leading to, or contributing to, serious complications that includes stroke. One prominent authority states that there is, at most, a one-in-a-million chance of such outcome.

Ancillary procedures and additional risks: Ancillary procedures sometimes used include light, vibration, massage, and therapeutic exercise. Vibration, massage, and exercise have risks similar to Chiropractic Adjustments; and vigorous exercise may pose a significant health risk to those with advanced cardiovascular disease.

Availability and nature of treatment options: Other treatment options include self-administered over-the-counter analgesics, rest, prescription drugs, hospitalization, surgery and rehabilitation. The material risks inherent in such options and the probability of such risks occurring are significant. Chiropractors may provide general information, but they do not provide medical advice. We strongly suggest that you consult a knowledgeable physician when making a decision to take or discontinue medications.

The risks and dangers attendant to remaining untreated: Remaining untreated may promote the formation of adhesions and reduction of mobility. A pain reaction may result that further reduces mobility. Over time this process may complicate treatment, making it more difficult and less effective, the longer it is postponed. The probability that non-treatment will later complicate rehabilitation is relatively high.

X-RAYS

_____ (patient initials) Recommended x-rays may be taken at any facility of your choosing

- X-rays films are kept as part of your permanent medical record. Copies are available in digital format. Please allow 5 – 10 business days after written request.

Flare-ups and injuries: It is your responsibility to tell the treating chiropractor if you've had a flare-up or new injury, before he / she starts treating you.

CONSENT

I have read or have had read to me the above explanation of the chiropractic examination, adjustment and related treatment. I have discussed any questions I have with the attending chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits of treatment and and have decided that it is in my best interest to undergo to the treatment recommended and give my consent to the aforementioned examination and treatment.

Signature (guardian if a minor)

relationship of
guardian to patient

Date



PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to provide you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or the dissemination of your personal information, we would be happy to address them.

I authorize Snohomish Family Chiropractic and their representatives to contact me by phone and email. I authorize Snohomish Family Chiropractic team to release any information to obtain payment for my services and to receive direct third-party payment for my services.

Patient Signature

I acknowledge that I have received a copy of the Snohomish Family Chiropractic Notice of *Privacy for Health Information*.

⌘ _____

Patient Name Printed

⌘ _____

Date

⌘ _____

Patient Signature

⌘ _____

Parent Name Printed (for minors)

⌘ _____

Parent Signature (for minors)

For the Member

I understand that I am responsible for all costs associated with chiropractic maintenance and wellness visits.

Parent Signature: ⌘ _____

Date: ⌘ _____