

PEDIATRIC CONSULTATION

(NEWBORN TO 1 MONTH OLD)

Patient information

Child's Name _____ Sex: M / F Date: _____
Child's SS#: _____ Child's Birthday: _____
Parent or Legal Guardian Name _____
Address: _____
City, State, Zip: _____ Home Phone: _____
Where do prefer to receive calls? _____ Work Phone: _____
Person to contact in case of emergency? _____ Phone: _____
Pediatrician? _____ Phone: _____

Responsible Party

Name of person responsible for this account: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to patient: _____
Method of payment of today's charges: Cash Check Charge

I hereby grant permission to Team Chiropractic to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.

Signature of Parent or legal guardian

Date

Authorization

I the undersigned have read and answered the above information to the best of my knowledge. The above questions have been accurately answered on behalf of my child. I understand that providing incorrect information can be dangerous to my child's health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such said chiropractic care to third party payers and/or health practitioners. Providing my insurance provides for the care of my child, I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand, provided my insurance is accepted and provides for my child, that the carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of parent or legal guardian

Date

PREGNANCY HISTORY

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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motor Vehicle Accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Near-miss MVA	<input type="checkbox"/>	<input type="checkbox"/>	_____
High B.P.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morning sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____

During Your Pregnancy, Did You Use Any Of The Following:

	Yes	No	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-prescribed drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____
Over-the-counter meds	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____

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		Yes	No
Hospital Birth	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Delivery	<input type="checkbox"/>	<input type="checkbox"/>
Home Birth	<input type="checkbox"/>	<input type="checkbox"/>	Planned C-section	<input type="checkbox"/>	<input type="checkbox"/>
Midwife assisted	<input type="checkbox"/>	<input type="checkbox"/>	Emergency C-section	<input type="checkbox"/>	<input type="checkbox"/>
Was birth induced (Pitocin)	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia administered	<input type="checkbox"/>	<input type="checkbox"/>
Forceps delivery	<input type="checkbox"/>	<input type="checkbox"/>	Fetal distress	<input type="checkbox"/>	<input type="checkbox"/>
Vacuum extraction	<input type="checkbox"/>	<input type="checkbox"/>	Meconium staining	<input type="checkbox"/>	<input type="checkbox"/>
Head presentation	<input type="checkbox"/>	<input type="checkbox"/>			
Face presentation	<input type="checkbox"/>	<input type="checkbox"/>			
Breech presentation	<input type="checkbox"/>	<input type="checkbox"/>			

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 ___
Medications given at birth? _____
Vaccines administered _____
Birth weight _____ lbs/kgs Birth length _____ inc/cms Baby home on day _____

NEWBORN HISTORY

How many hours does your baby sleep between feedings? During day _____ Night _____

Yes No

- Does your baby go to sleep easily? _____
 - Does baby have a preferred sleeping position? _____
 - Does baby cry if you change this sleeping position? _____
 - Does baby have any feeding difficulties? _____
 - Is baby being breast fed? If no, for how long was baby breast fed? ___ wks. mos.
 - Does baby have a one-sided breast preference? Preferred breast: Left Right
 - Is baby formula fed? Which formula or other milk source? _____
 - Does baby frequently spit up after feeding? _____
 - Does your baby cry a lot? For how many hours each day? _____
 - Does baby pass a lot of intestinal gas? _____
 - Does baby have a preferred head position? _____
 - Does baby frequently arch his/her head and neck backwards? _____
 - Does baby cry or become irritable during diaper change? _____
 - Has baby ever had a fever? _____
 - Has baby ever had any falls? _____
 - Has baby ever been in a car accident or near-miss? _____
 - Has baby had any other trauma? _____
 - Has your baby been vaccinated? _____
 - Do you have any other concerns you wish to discuss? _____
-

Parent Consent

I, _____, hereby consent to Team Chiropractic permission to call my home, cell, and work number for appointment reminders and routine office needs regarding my child's account.

I hereby consent for Team Chiropractic to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____

I hereby revoke any information to be given to the following family members regarding any routine office needs here at Team Chiropractic:

_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____
_____ Relation: _____

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

“I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein.”

Patient Name, printed

Legal Guardian/Parent Signature

Date

CHIROPRACTIC ORIENTATION

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: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

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

Health: a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae 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 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, _____, have read and fully understand the above statements.

Signature

Date