

## 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 relating 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 that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

# 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?	<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 _____

**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? \_\_\_\_\_

\_\_\_\_\_

# 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Home birth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Midwife assisted	<input type="checkbox"/>	<input type="checkbox"/>	_____

Vaginal Delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Planned C-section	<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"/>	_____
Forceps delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vacuum extraction	<input type="checkbox"/>	<input type="checkbox"/>	_____

Anesthesia administered	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fetal distress	<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 Unit \_\_\_\_

Medication given at birth? \_\_\_\_\_ Vaccines administered \_\_\_\_\_

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

**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 do 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 \_\_\_\_\_



**OFFICE USE ONLY***Vitals: In EZnotes, complete by*

- 1) Going to "Exam" screen
- 2) "Select by region"
- 3) Then select "Vitals"

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Smoking Status: 

Smokes every day	Smokes some days	Former Smoker	Never Smoked
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**PRESCRIBED MEDICINES**Check here if not taking any medications: ☐

Medication: i.e. Lipitor	# of MD refills issued:	Quantity of Pills:	Strength: i.e. 10 mg	Dose Form: i.e. Capsule	MD's instruction: i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	Symptom: i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?
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I would like to electronically have access to my health information: (Please initial box)

☐**OFFICE USE ONLY***Timely access: In EZnotes, complete by*

- 1) Going to "Edit Patient" section for this patient
- 3) Select "Asked Timely Access"

☐

Completed?

*Medications: In EZnotes, complete by*

- 1) Going to "Edit Patient"
- 2) "Edit /View Patient's Data"
- 3) "Prescriptions/Allergies"

☐

Completed?

Entered into EZnotes by (name): \_\_\_\_\_ Date &amp; Time: \_\_\_\_\_



## Results Chiropractic Inc: PHI Disclosure Log

**Date**

**PHI Released**

**Recipient of PHI**

**Released by:**
