

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 the 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 _____

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 _____

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? _____

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 occurring 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? _____

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.

YEARLY PATIENT UPDATE FORM

We thank you for your cooperation in keeping your records up-to-date.

TODAY'S DATE: _____

PATIENT NAME: _____ SSN: _____

(If you prefer not to provide your whole SSN, please provide the last four digits)

DATE OF BIRTH: _____ AGE: _____ Male _____ Female _____

Married _____ Single _____ Divorced _____ Separated _____ Other _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

CARRIER: _____

(If you provide us with your cell phone number and/or home phone numbers, please provide us with the carrier's name, i.e. Verizon, AT&T, Sprint, etc. In providing this information, your signature below gives us permission to Text Message appointment reminders and other messages as may be appropriate.)

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

WORK PHONE: _____ (Permission to call? yes no)

EMPLOYER NAME: _____

ADDRESS: _____

PRIMARY PHYSICIAN NAME: _____ PHONE: _____

SPOUSE'S NAME: _____ DOB: _____ SS# _____

SPOUSE'S EMPLOYER NAME: _____ Occupation: _____

ADDRESS: _____

PHONE: _____ (Permission to call? yes no)

PLEASE PROVIDE THE STAFF WITH YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE WHEN RETURNING THIS INFORMATION TO THE DESK. THANK YOU.

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE: _____

IF PATIENT IS A MINOR, YOUR NAME & RELATIONSHIP: _____

RESULTS CHIROPRACTIC INC.

A Family Wellness Center

JOHN S URBAN III DC, CCSP and LETTY L URBAN DC, DICCP

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing him/her/their, any and all records and reports, including x-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment, or opinion concerning that I may have had in the past, now have, or may have in the future.

Please forward all requested reports, x-rays and/or information to Results Chiropractic Inc. A copy of this release of information shall be as valid as the original.

Signature

Date of Birth

I give my permission to release information regarding myself to _____,
which I may revoke in writing at any time.

Signature

H I P P A

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there should be anyone you do not want to receive your medical records, please inform our office staff.

By signing below I also release Results Chiropractic Inc. from any responsibility should I choose to engage in electronic exchange of information (texting, email, etc.) with any of the providers of service at Results Chiropractic Inc. regarding myself, minor, or other individual of which I have guardianship, ie, if such personal information is intercepted by anyone other than the mail recipient.

Patient's Signature _____ Date _____
Guardian's Signature Authorizing Care _____ Date _____
Initial here _____ if our office can use your name on our web site/newsletter.

Correspondence Address: P O Box 235 – Beverly OH 45715
Two Locations: 643A STRT 821 Bldg 4 - Marietta OH 45750 and 519 Fifth Street – Beverly OH 45715
(740) 678-2700
(740) 678-2777 FAX

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

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?

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 & Time: _____

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 _____

