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?	☐	☐	_____
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?	☐	☐	_____

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

	Yes	No				
Tobacco?	☐	☐	_____			
Alcohol?	☐	☐	_____			
Non-prescribed drugs?	☐	☐	_____			
Prescription medications?	☐	☐	Medication	_____	Reason	_____
Over-the-counter meds?	☐	☐	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	☐	☐	_____
Home birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	_____
Emergency C-section	☐	☐	_____
Was Birth Induced (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____
Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
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 _____ 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 _____

INFANT HISTORY

2 months to 2 years

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age ___

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION

Yes ☐ No ☐ Is your child still being breast fed? If no, for how long was he/she breast fed _____

If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes ☐ No ☐ Is your child formula fed? Which formula or other milk source? _____

Yes ☐ No ☐ Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Yes ☐ No ☐ Does your child have any feeding difficulties? _____

Yes ☐ No ☐ Does your child have any digestive disturbances? _____

Yes ☐ No ☐ Does your child have any food allergies? _____

Yes ☐ No ☐ Does your child have any persistent or intermittent skin rashes? _____

Yes ☐ No ☐ Is your child receiving any vitamin supplements? _____

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 down stairs or fallen from any 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? _____

INFANT HISTORY

2 months to 2 years

GROWTH AND DEVELOPMENT

Yes ☐ No ☐ Can your child sit unsupported? At what age did your child start to sit-up? _____ mths

Yes ☐ No ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

Yes ☐ No ☐ Is your child walking yet? At what age did your child start to walk? _____ mths

Yes ☐ No ☐ Does your child often trip and fall? _____

Yes ☐ No ☐ Does your have any other concerns about your child's growth and development? _____

HEALTH HISTORY

Yes ☐ No ☐ Has your child had colic? _____

Yes ☐ No ☐ Has your child had any upper respiratory infections? How often? _____

Yes ☐ No ☐ Has your child had asthma? _____

Yes ☐ No ☐ Does your child ever complain of back or neck pain? _____

Yes ☐ No ☐ Does your child ever complain of pains in the arms or legs? _____

Yes ☐ No ☐ Does your child ever complain of headaches? _____

Yes ☐ No ☐ Has your child had any earaches ? At what age did the first earache occur _____

Yes ☐ No ☐ How frequently does your child have earaches? _____

Yes ☐ No ☐ Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? ___

Yes ☐ No ☐ Has your child had any other illnesses?
Please list each illness and its approximate date _____

_____

Yes ☐ No ☐ Is your child presently receiving any medications ? _____

Yes ☐ No ☐ Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes ☐ No ☐ Has your child recently been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns about your child's health? _____

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: _____

_____

Rev 11/01/2017

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

HIPPA

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: PHI Disclosure Log

Date	PHI Released	Recipient of PHI	Released by:

Rev 09/2013

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 don 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_____