# 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: ____________________________

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# 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 __________ |

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# 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 ________

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# SCHOOL-AGE CHILD HISTORY
## 6 years and Older

Today's Date ____________

Name ______________________ Sex: M F Date of Birth __________ Age ____

Reason for Today's Visit ______________________________

When did this problem first occur? ______________________________

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Have you ever had this problem before? ____________ |
| ☐ | ☐ | Have you previously been treated for this problem? Doctor's name ____________ |
| ☐ | ☐ | Have you previously been to a chiropractor? When? ____________ |

**ABOUT YOUR HEALTH**
In the past year have you had any of the following

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Back or neck pain? ____________ |
| ☐ | ☐ | Pains in the legs or arms? ____________ |
| ☐ | ☐ | Headaches? ____________ |
| ☐ | ☐ | Asthma? ____________ |
| ☐ | ☐ | Allergies? ____________ |
| ☐ | ☐ | Earaches? ____________ |
| ☐ | ☐ | Falls from a bicycle, skateboard, scooter, rollerblades or similar? ____________ |
| ☐ | ☐ | Do you ever have a problem with bedwetting? ____________ |
| ☐ | ☐ | Have you ever been in a motor vehicle accident? ____________ |
| ☐ | ☐ | Have you ever had any broken bones? ____________ |
| ☐ | ☐ | Have you ever had any surgeries? ____________ |
| ☐ | ☐ | Are you at present taking any medications? ____________ |
| ☐ | ☐ | Do you have any other health problems? ____________ |



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# SCHOOL-AGE CHILD HISTORY
## 6 years and Older

### ABOUT YOUR LIFESTYLE

What grade are you in at school? ______

How do you carry your school books? ______

How heavy is your school book bag? ______

What sports do you play? ______

What hobbies do you have? ______

How many hours each day do you watch TV? ______

How many hours each day do you spend using a computer? ______

How often do you play video games? ______

On average, how many hours sleep do you get each night? ______

Are there any smokers in your family? ______

Do you feel stressed out? ______

Do you have trouble reading the board in class? ______

Do you ever have blurred vision? ______

Do you wear glasses or contact lenses? ______

Do you sometimes get headaches when you read? ______

### ABOUT YOUR DIET

What do you usually eat for Breakfast? ______

______

What do you usually eat for Lunch? ______

______

What do you usually eat for Dinner? ______

______

What snacks do you have after school? ______

What is your favorite food? ______

How much water do you drink each day? ______

How many sodas or colas do you drink each day? ______

How often do you eat fast food items? ______



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# 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

## 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 |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |

**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: |
|---|---|---|---|
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# 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__________________