NEW SPRING CHIROPRACTIC

**Pediatric New Patient Information**

**PATIENT INFORMATION**

Child's Full Name: _____ Nickname: _____
Reason for visit: _____
Sex: M / F Date of Birth: _____ Age: _____ 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 #: _____
Email: _____
Parent's marital status (please circle): Married Single Divorced Widowed
List ages of other children in family: _____
Language used at home: _____

**Please read, sign and date:**

- I understand that I am financially responsible to New Spring Chiropractic for all charges incurred and not covered by insurance.
- I understand any balances over 30 days are subject to accrued interest of 1.5 percent per month.
- I have read all information in this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.
- I agree to notify staff immediately if my contact number changes and will not hold New Spring Chiropractic responsible for text messages that are sent to the wrong number because of lack of notification.

Patient Signature _____ ☐ Parent (if minor) Date: _____

- I agree to pay a no-call, no-show fee of $25 on subsequent appointments if I have a scheduled appointment and don't show up. (Reschedules are always welcome.)

Patient Signature _____ ☐ Parent (if minor) Date: _____

NEW SPRING CHIROPRACTIC

**PREGNANCY HISTORY**

Today's Date: _____ Child's Name: _____

What was the term of your pregnancy? _____ Weeks + _____ Days

**DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING?**

| | YES | NO | |
|---|---|---|---|
| Falls | ☐ | ☐ | |
| Motor Vehicle Accidents | ☐ | ☐ | |
| "Close call" MVA | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | |
| 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?**

| | | | |
|---|---|---|---|
| Tobacco | ☐ | ☐ | |
| Alcohol | ☐ | ☐ | |
| Non-Prescribed Drugs | ☐ | ☐ | |
| Prescription Medications | ☐ | ☐ | Medication/Reason: _____ |
| Over the Counter Meds | ☐ | ☐ | Medication/Reason: _____ |

NEW SPRING CHIROPRACTIC

**BIRTH HISTORY**

Today's Date: _____ Child's Name: _____

**LABOR AND DELIVERY**

How long was the labor from the 1st regular contraction to birth? _____

How long was the 2nd stage (pushing phase) of labor? _____

| | YES | NO | |
|---|---|---|---|
| Hospital Birth | ☐ | ☐ | |
| Home Birth | ☐ | ☐ | |
| Birth Center | ☐ | ☐ | |
| OB/GYN | ☐ | ☐ | |
| Midwife | ☐ | ☐ | |
| Unassisted | ☐ | ☐ | |
| Vaginal Delivery | ☐ | ☐ | |
| Planned C-Section | ☐ | ☐ | |
| Emergency C-Section | ☐ | ☐ | |
| Induced (Pitocin) | ☐ | ☐ | |
| Forceps Delivery | ☐ | ☐ | |
| Vacuum Extraction | ☐ | ☐ | |
| Anesthesia | ☐ | ☐ | |
| 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: Immediate_____ Cried strongly_____ Weak cry _____ Did not cry for _____ min

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 NICU_____

Medications given at birth _____

Vaccines administered _____

Birth Weight_____ lbs. /kg Birth Length_____ ins/cms

Baby home on day_____

NEW SPRING CHIROPRACTIC

**NEWBORN HISTORY**
**0-12 months**

Today's Date: _____ Child's Name: _____

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 feedings?
During the day: _____ During the night: _____

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Does your baby go to sleep easily? |
| ☐ | ☐ | Does baby have a preferred sleep position? |
| ☐ | ☐ | Does baby cry if you change this sleeping position? |
| ☐ | ☐ | Does baby have any feeding complications? |
| ☐ | ☐ | Is baby breast fed? If no, for how long was baby breast fed? |
| ☐ | ☐ | Does baby have a one-sided breast feeding preference? |
| ☐ | ☐ | Is baby formula fed? Brand or milk source? |
| ☐ | ☐ | Does baby frequently spit-up after feeding? |
| ☐ | ☐ | Does baby cry a lot? If yes, how many hours/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 a diaper change? |
| ☐ | ☐ | Has baby ever had a fever? |
| ☐ | ☐ | Has baby had any falls? |
| ☐ | ☐ | Has baby been in a car accident or near-miss? |
| ☐ | ☐ | Has baby had any other trauma? |
| ☐ | ☐ | Has baby been vaccinated? |
| ☐ | ☐ | Do you have any other concerns? |

# Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays and spinal decompression, physical examination, or any other medical procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with the following clinic: New Spring Chiropractic

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:

**HIPAA Compliance Acknowledgement of Receipt**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notices of our privacy practice. We protect your health information and what rights you have regarding it, if we need to disclose your health information outside of our office for these reasons we will ask for your written permission. If you would like a copy of this policy please feel free to ask for one.

I acknowledge that I have reviewed this policy and that I was offered a copy of the "Notices of Privacy Practices."

Signature: _____ Date: _____

## Release of Information Authorization- I hereby authorize New Spring Chiropractic to release information.

**Information to Be Used or Disclosed-** The information covered by this authorization includes:

☒ Healthcare and Financial Records (Healthcare records include examination findings, diagnoses, treatments, lab/imaging results)
☐ Healthcare records
☐ Financial Records

**Persons to Whom Information May Be Disclosed-** Information described above may be disclosed to:

☒ All of the Following:
☐ Primary Insurance Carrier
☐ Secondary Insurance Carrier
☐ Other Healthcare Provider as described above
☐ Personal Attorney
☐ Guardian/ Parent
☐ Spouse
☐ Release to: _____

Signature: _____ Date: _____