New Practice Member Initial Interview - Child

Welcome to Restore Chiropractic Center. Your time here today is as important for you as it is for us. The information you fill in here is paramount to the Chiropractor reaching conclusions and directional decisions about your child's health, from the past to the present and into the future. If there is anything you're not sure of then please don't hesitate to ask one of our friendly team members.

About the Child:

Last Name: _____ First: _____ Preferred Name: _____

Gender: Male Female Date of Birth: _____ Age: _____

About the Parent/Guardian:

Name: _____ Birthdate: _____ Age: _____

Mailing Address: _____Zip Code_____

Occupation_____Employer_____

Email: _____

Spouse's Name: _____

Phone: H: _____ Cell: _____

Reason for the visit:

Describe the reason for the visit (Please be specific):

_____

_____

When did this start? _____

Has the condition been: Staying the Same Getting Worse Getting Better

Have you see other Doctors for this condition? _____

_____

How would you describe the intensity/sensation? Sharp Dull Burning Numbness Other: _____

Child's Health History:

Please circle all that apply or have applied to you child:

Allergies	Asthma	ADHD	Bed Wetting	Breathing Problems
Colic	Constipation	Digestive Problems	Ear Problems	Frequent Colds
Headaches	Irritability	Sleeping Disorders	Tubes in Ears	Vision Problems

Other:_____

Is your child currently taking any medications?_____

Number of doses of antibiotics your child has taken?

During the past 6 months:_____ Total during his/her lifetime: _____

Mother's Pregnancy and Labor:

During the pregnancy, did you use: Drugs Tobacco Medications Alcohol

If yes, please describe: _____

Name of Obstetrician/Midwife: _____

Location of Birth: [ ] Hospital [ ] Birthing Center [ ] Home

Birth Interventions: [ ] Forceps [ ] Vacuum Extraction [ ] Cesarean Section
[ ] Pitocin/Induced [ ] Epidural [ ] Premature Birth

Position of the Baby: [ ] Vertex [ ] Breech [ ] Brow/Face [ ] Transverse

Birth Weight: _____ Birth Height: _____ APGAR Score: _____

Yes **No** Did you experience any illness when pregnant? _____

Yes **No** Did you have ultrasounds preformed? How many? _____

Yes **No** Did the baby have colic? _____

Yes **No** Did you choose to vaccinate your child? _____

Yes **No** Did you nurse the baby? How long? _____

Food Allergies or Intolerances: **Yes** **No** If yes, please explain: _____

_____

Child's Health History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs).

Was this the case with your child? **Yes** **No**

Is/has your child been involved in any sports? Please list: _____

_____

Has your child ever been involved in a car accident? **Yes** **No** List: _____

Has your child been seen on an emergency basis? **Yes** **No** List: _____

Any prior surgeries? **Yes** **No** List: _____

Other physical traumas not described above? _____

Has your child suffered any emotional traumas? _____

Childhood Diseases:

Chicken Pox: **Yes** **No** Age: ____ Mumps: **Yes** **No** Age: ____

Whooping Cough: **Yes** **No** Age: ____ Rubella: **Yes** **No** Age: ____

Rubeola: **Yes** **No** Age: ____ Other: _____

I CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

New Practice Member Name (please print):_____ Date: _____/_____/_____

Name and Signature of parent or legal guardian: _____ (If <18 years of age):

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Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities.

Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

The following office procedures allow Restore Chiropractic to operate in an efficient manner and allow us to support our practice members with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We many need to contact you by telephone or text at home or at work regarding appointments and other matters related to care/appointments in this office.
- We may need to leave a message with another person (spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publically thank you on the office bulletin board. We also have "Patient of the Week" and "Family of the Month", if selected we would like to recognize you by posting a sign on the office bulletin board, on our Facebook page and social media websites, and on our website.
- We often take and post photos of our practice members in the office, in our newsletters, on Facebook and social media sites, and on our website.

You have the right to refuse any of this authorization without affecting your care or the relationship with anyone at Restore Chiropractic. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:** _____

Restore Chiropractic Center

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Medical Information (HIPAA) Release Form

Name: _____ **Date of Birth:** ____ / ____ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis; records; examination rendered to me; and claims, billing, and account information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Attorney _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

PATIENT NAME (PLEASE PRINT):_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:** _____

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Informed Consent Form

Chiropractic care is recognized as being an effective and safe method of care for many areas of life.

However, as in all health care, there are some very slight risks with chiropractic care.
This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [1];
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments) [2] [3].

*Put in context, chiropractic has been shown to be **250 times safer** than anti-inflammatory drugs [4] and safer than driving a car [5].*

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding [6] [7]. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates *unexpected improvement* in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health.[8] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14%: eyes/vision.

Broken down into subcategories the benefits were reported as follows:

- Easier to breathe: 21%,
- Improved digestive function: 20%,
- Clearer/better/sharper vision: 11%,
- Better circulation: 7%
- Changes in heart rhythm/blood pressure: 5%,
- Less ringing in the ears/improved hearing: 4%

(The reference for the information quoted above are available upon request.)

Agreement:

I have read and understood the information above. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise his/her judgment during the course of care which he/she feels at the time, based upon the facts known, is in my best interests. I have, to the best of my knowledge, provided the chiropractor with a complete and accurate health history. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation at Restore Chiropractic. I hereby request and consent to chiropractic adjustments and other chiropractic suggestions wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Print name: _____ **Signature:** _____
(Parent /guardian if under 18 years)

Chiropractor's signature: _____ **Date:** _____

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8):530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9):42-47.
(6) Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15;22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999;22:559-64.