Health First Chiropractic & Wellness Center

PATIENT INFORMATION (Birth to 2 Years)

Please print clearly:

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

DATE OF BIRTH: _____/_____/_____ M / F

PARENT NAME: _____

PARENT CELL #: (_____) _____- _____

PARENT E-MAIL: _____

SIBILINGS and AGES:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

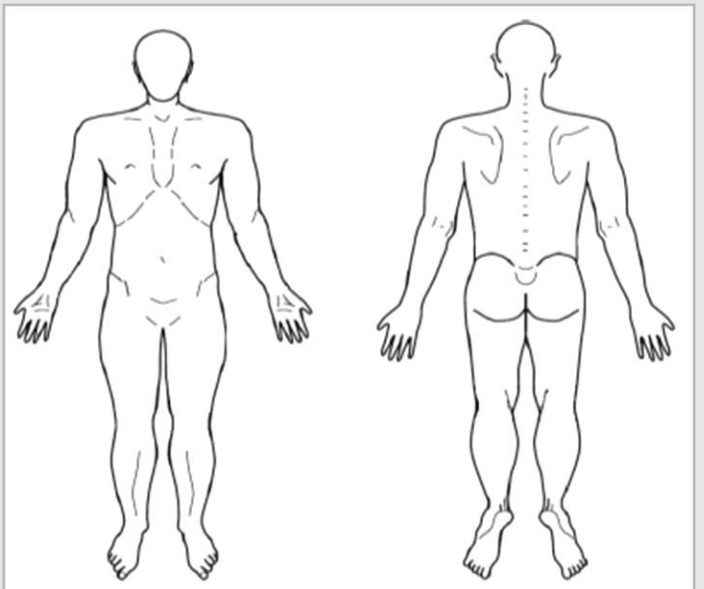
REGULAR PEDIATRICIAN:

_____

PHONE #: (_____) _____ - _____

To Whom may we thank for referring you?

_____



Primary reason you are seeking our help:

_____

_____

If you have any specific areas you would like us to address, please mark the area of concern on the above diagram.

How long has you child had this problem?

_____

Does the reason for your visit today involve:

Auto Accident claim? YES / NO

Has your child been seen by a chiropractor before?

YES / NO

If yes, Who? _____

Reason for care? _____

_____

Were x-rays taken? YES / NO

Approximate dates of care: _____

_____

Health First Chiropractic & Wellness Center
530 Madison Street - St. Charles, MO 63301
(636) 946-3600 FAX (636) 946-3019

MEDICAL HISTORY:

List all operations for your child and approximate dates:

_____

_____

List all medications your child is currently taking and why:

1. _____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

WHY WE CHECK CHILDREN

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and stress on this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

Today will help reveal the causes of any Vertebral Subluxations which may interfere with the optimal function of your child's nervous system and therefore impair your child's inborn ability to be healthy.

CORRECTION

Today, we are becoming more aware, how modern lifestyles choices expose our children's nervous systems to a variety of stresses.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider trained and qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the chiropractic adjustment is the beginning of greater health and well-being for your child.

I, _____ (parent/legal guardian) understand this office is not offering to treat symptoms and disease. I understand the purpose of _____ (minor's name) examination is to determine how to improve the overall health of their spine and nervous system.

I understand this office DOES NOT participate in, not a provider for, or accept ANY Insurance/Medicare/Medicaid. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I understand this office is not offering to treat symptoms and disease. I understand the purpose of my examination is to determine how to improve the overall health of my spine and nervous system. I hereby authorize the doctors at Health First Wellness Center and/or their assistants to perform _____ (minor's name) initial health examination. I certify that the information in this entire intake form is true and correct.

_____ _____

Parent / Legal Guardian Signature Date

_____ _____

Printed Name Relationship

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HEALTH HISTORY: Birth to 2 Years

CHILD'S NAME: _____ TODAY'S DATE: _____

BIRTH PROCESS

1. Did you have an ultrasound during this pregnancy? YES / NO Frequency? _____
   - Place of birth:
     - ☐ Home
     - ☐ Birthing Center
     - ☐ Hospital
   - Provider:
     - ☐ Midwife
     - ☐ OB-GYN
     - ☐ Other _____
   - Type of Birth:
     - ☐ Vaginal
     - ☐ C-Section
   - Was anesthesia used? YES / NO Type? _____
   - Was labor induced? YES / NO If YES, why? _____
   - What position did you deliver in?
     - ☐ Squatting
     - ☐ On Back
     - ☐ Other _____
   - Birth Method:
     - ☐ Doctor assisted
     - ☐ Twisted, Pulling
     - ☐ Vacuum Extraction
     - ☐ Forceps
   - Newborn birth distress (medical procedures and test) _____

SLEEP

- Does your child go to sleep easily? YES / NO
- Does your child have a preferred sleeping position? YES / NO
- Does your child have a preferred direction to turn their head? YES / NO If YES, Right / Left
- Does your child cry if you change this position? YES / NO

EATING

2. Is your child being breastfed? YES / NO If NO, for how long was your child breastfed? _____
   - Does your child have a one-sided breast-feeding preference? YES / NO
     Preferred breast? Right / Left
   - Is your child formula fed? YES / NO If YES, which formula or other milk source? _____
   - Does your child have any feeding difficulties? YES / NO
3. Does your child frequently spit-up after feeding? YES / NO
4. Does your child cry or become irritable during a diaper change? YES / NO
5. Is your child eating solid food? YES / NO
   If YES, what foods does his/her diet contain? _____
   What is your child's favorite food? _____
   - Does your child have any digestive disturbances? YES / NO
   - Does your child pass a lot of intestinal gas? YES / NO
   - Has your child had colic? YES / NO
   - Does your child have any food allergies? YES / NO If YES, describe: _____
   - Does your child have any persistent or intermittent skin rashes? YES / NO
   - Is your child receiving any vitamin supplements? YES / NO If YES, describe: _____

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HEALTH HISTORY: Birth to 2 Years

DEVELOPMENTAL

6. Can your child sit unsupported? YES / NO At what age did this begin? _____
7. Is your child comfortable with tummy time? YES / NO
   - Is your child crawling? YES / NO At what age did this begin? _____
   - Is your child walking? YES / NO At what age did this begin? _____
   - Does your child often trip and fall? YES / NO

INJURIES / PAIN / ILLNESS

8. Can you recall any jolts, falls, or major traumas to your child? YES / NO
   Please describe any such injuries _____
   Any fractures or dislocations? _____
   - Has your child ever been to a hospital or emergency room for evaluation or treatment? YES / NO
     Has your child had any surgeries? YES / NO
     If YES to either, please describe: _____
   - Has your child ever been in a car accident? YES / NO

9. Does your child cry frequently? YES / NO If YES, for how many hours each day? _____
   - Does your child frequently arch his/her head and neck backwards? YES / NO
   - Does your child show signs of back or neck pain? YES / NO _____
   - Does your child show signs of pain in the arms or legs? YES / NO _____
   - Does your child show signs of headaches? YES / NO _____
   - Does your child ever bang his/her head repeatedly against a wall, bed, or other object? YES / NO

   - Has your child ever had a fever? YES / NO
   - Has your child experienced earaches? YES / NO If YES, at what age did this first occur? _____
   - Do earaches tend to occur in the same ear? YES / NO Right / Left / Both
   - Does your child have asthma? YES / NO
   - Has your child had upper respiratory infections? YES / NO If YES, how often? _____
   - Has your child been seriously ill? YES / NO
     Please list illnesses with approximate date _____
     _____
   - Has your child been treated with drugs? YES / NO If YES, for what? _____
   - Has your child ever been on antibiotics? YES / NO If YES, for what? _____
     If YES, did you re-balance their gut flora with a probiotic after? YES / NO
   - Is your child currently on any medications? YES / NO
     Please list medications _____

VACCINATIONS:

- Did your child experience any behavioral, emotional, or physical changes within 3 months of any shots? YES / NO If YES, please describe_____
  _____
- Was it reported to your doctor? YES / NO

Do you have and other questions or concerns you would like to discuss?

_____

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Health First Wellness Chiropractic Clinic

Palmer Specific Chiropractic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND
(Patient's Name)

AGREE AS FOLLOWS:

1. The Practice's Privacy notice will be offered to me (upon request) prior to my signing this Consent. The Privacy notice includes a complete description of the uses and /or disclosures of my *protected health information* ("PHI") necessary for the Practice to provide treatment of me, and also necessary for the Practice to obtain payment of that treatment and to carry out its' health care operations. The practice explained to me that the Privacy notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its' privacy practices that are described in its' Privacy notice, in accordance with applicable law.
3. The Practice may use and /or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice had already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

Date Signed _____/_____ /_____ Witness: _____

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This Document Constitutes Informed Consent for Chiropractic Examination and Care

When a patient seeks straight chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Straight chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The **Vertebral subluxation** is the misalignment of spinal bones causing interference to the mental impulses traveling over the nerve pathways. The objective of straight chiropractic is to analyze the spine and locate and correct these vertebral subluxations. The straight chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE, is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize the doctor to perform a chiropractic examination to determine the presence of vertebral subluxation.

I hereby authorize the taking of x-ray films if necessary. I further agree that the above-mentioned doctor shall be the custodian of these x-rays.

All questions regarding the doctor's objective pertaining to detection of vertebral subluxation have been answered to my complete satisfaction.

I, _____ have read and fully understand the above statement.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I_____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination and adjustment if necessary.

_____ _____
(SIGNATURE) (DATE)

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