BABY HISTORY FORM

Date _____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know and we will be happy to assist you.

Child's Name _____ D.O.B. _____

Home Telephone _____ Home Address _____

Doctor's Name _____ Doctor's Address _____

Doctor's Phone Number _____

Date of Last Visit (mm/dd/yyyy) _____

Name of previous Doctor of Chiropractic _____

Child's Height _____ Child's Weight _____

Name(s) Parents/Guardians _____

Business Phone Number _____

I herby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____

Witness _____

What are your chief concerns, if any, with your child's health? _____

_____

What is your main reason for contacting us? _____

List any other care your child has undergone with regards to this complaint including medication

_____

Date of onset (mm/yyyy) _____ Onset was: Sudden Gradual Assoc. with event

Duration of problem: Minutes Hours Days Months Years

Pattern of problem: Constant Intermittent Occasional Cyclical

Initiating Factors _____

Aggravating Factors _____

Relieving Factors _____

BABY HISTORY FORM

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Any other information you wish to tell the doctor? _____

_____

BABY INTAKE FORM

Please circle response

Hospital/Birthing Center Home Hospital Midwife Duration of Gestation _____ weeks

Was the birth assisted? Yes No **If yes:** Forceps Vacuum Extraction C-Section Induced Labor

Were medications given to mother at birth? Yes No **If yes, what?** _____ Duration of labor_____

Was delivery normal? Yes No **If no, what were the complications?** _____

APGAR at birth _____

Growth and Development APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Was the infant alert & responsive within 12 hours of delivery? Yes No If no, explain _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold up head _____

Sit alone _____Teethe _____ Crawl _____ Walk_____ Are sleep patterns normal? Yes No

Describe any health problems on mother's side of the family (cancer, diabetes, etc.)

_____

The father's side:_____

Do the child's siblings have any health problems? Yes No If yes, describe _____

Any complications during pregnancy?

Mother _____

Child _____

The following information is very important because many of the problems that chiropractors work on are caused by stressors.

Chemical Stressors

During pregnancy, did mother: Smoke Yes No Drink Alcohol Yes No Supplements/vitamins Yes No

Take drugs Yes No Is yes, what? _____ Become ill? Yes No If so, how? _____

Receive ultrasounds Yes No If yes, how many? _____

Receive invasive procedures (amniocentesis, CVS?) Yes No

Was your child breastfed? Yes No Is yes, for how long? _____ weeks months years

At what age was formula introduced (if at all) _____ Brand? _____

Cow's Milk _____ yrs Solid food?_____ yrs

Did your child receive vaccinations? Yes No If yes, which ones? _____

Did your child react to the vaccinations? Yes No

Has your child had antibiotics? Yes No If yes, how many courses has the child had, why? _____

Psychological Stressors

Any difficulties with lactation? Yes No Any problems bonding? Yes No

Does your child seem normal to you? Yes No Does your child have behavioral problems? Yes No

If yes, explain _____

Does your child have difficulties sleeping (night terrors, sleepwalking, etc) Yes No

If yes, explain _____

Did (does) your child go to daycare? Yes No From what age?_____

Average # of hours of TV/Computer per week? _____

Traumatic Stressors

Any evidence of trauma during birth? Bruises Odd shaped head Stuck in birth canal Fast/long birth

Respiratory depression Cord around neck Other _____

Any falls/accidents during pregnancy? Yes No Has the child had any major falls since birth? Yes No

If yes, did the child need stitches or cause a fracture? Describe _____

Any hospitalizations? Yes No If yes, explain _____

Does your child play sports? Yes No Number of hours per week? _____

Age child began _____

Weight of school back pack? _____ Average # of hours at play per week _____

HEALTH HISTORY

Fear Paralysis Reflex

- [ ] Low tolerance to stress
- [ ] Anxiety
- [ ] Sensory processing issues
- [ ] Hypersensitivity to light
- [ ] Hypersensitivity to sound
- [ ] Does not adapt to change well
- [ ] Overly clingy
- [ ] Extreme fatigue
- [ ] Selective mutism (not speaking in situations where talking is expected)
- [ ] Holding breath when angry or upset
- [ ] Obsessive-compulsive disorder (OCD) traits
- [ ] Defiant or controlling behavior

Plantar Reflex

- [ ] Did not crawl normally on hands and knees
- [ ] Poor balance
- [ ] Poor handwriting

Rooting and Suck Reflexes

- [ ] Difficulty chewing or swallowing
- [ ] Difficulties feeding
- [ ] Poor speech
- [ ] Poor articulation
- [ ] Lack of manual dexterity
- [ ] Poor appetite
- [ ] Picky eater
- [ ] Digestive issues
- [ ] Drooling
- [ ] Chews on items while concentrating
- [ ] Thumb sucking, nail biting
- [ ] Need for orthodontic treatment
- [ ] Separation anxiety

Tonic Labyrinthine Reflex (Forward)

- [ ] Poor posture
- [ ] Car sickness
- [ ] Dislikes sporting activities
- [ ] Poor sense of time

Tonic Labyrinthine Reflex (Backwards)

- [ ] Poor balance and coordination
- [ ] Motion sickness
- [ ] Growing pains in legs
- [ ] Delayed walking
- [ ] Toe-walking
- [ ] Poor posture *i.e. head slumped forward*

Babinski Reflex

- [ ] Poor grounding and stability
- [ ] Difficulty with gross and fine motor coordination
- [ ] Passive in decision making
- [ ] Timid
- [ ] Toe-walking

Palmar Grasp

- [ ] Poor handwriting
- [ ] Poor speech
- [ ] Poor articulation
- [ ] Poor fine muscle control
- [ ] Moves mouth or tongue when using hands *i.e. drawing*
- [ ] Poor manual dexterity
- [ ] Poor pencil grip
- [ ] Hypersensitive palms

Asymmetric Tonic Reflex (ATNR)

- [ ] Mixed laterality *i.e. right-handed and left-footed*
- [ ] Poor eye-hand coordination
- [ ] Poor upper and lower limb coordination
- [ ] Difficulty reading and writing
- [ ] Poor distant vision
- [ ] Poor balance
- [ ] Difficulty with sports

Asymmetric Tonic Reflex (ATNR)

- [ ] Did not crawl on hands and knees *i.e bear crawled*
- [ ] Poor posture
- [ ] "W" sitting with legs on floor
- [ ] Poor hand-eye coordination
- [ ] Difficulty changing focus easily from whiteboard to desk
- [ ] Difficulty with copying words

HEALTH HISTORY

Moro Reflex

- [ ] Poor coordination
- [ ] Difficulty catching a ball
- [ ] Motion sickness
- [ ] Sensitivity to light
- [ ] Sensitivity to loud noise
- [ ] Difficulty reading black print on white paper
- [ ] Easily distracted
- [ ] Allergies
- [ ] Eczema
- [ ] Asthma
- [ ] Dislike of change
- [ ] Clingy
- [ ] Shy
- [ ] Hypersensitive to hair brushing, nail trimming, having face washing, wearing certain fabrics

Spinal Galant Reflex

- [ ] Bed wetting
- [ ] Constant fidgeting
- [ ] Unable to sit up straight
- [ ] Extremely ticklish
- [ ] Dislikes elastic waistbands or tags
- [ ] Poor concentration
- [ ] Poor short term memory
- [ ] Not moving arms with walking
- [ ] Poor mobility with sports
- [ ] Low back pain
- [ ] Shallow breathing
- [ ] Digestive issues

Spinal Perez Reflex

- [ ] Poor head-leveling
- [ ] Low muscular tone *i.e. difficulty holding up head*
- [ ] Abnormal gait
- [ ] Tunnel vision
- [ ] Delayed crawling, frog-jump crawling
- [ ] Hyperactivity
- [ ] Sensory processing disorders
- [ ] Fears/phobias
- [ ] Bed wetting
- [ ] Discomfort with tightly-fitted clothes

Head-Righting Reflex (if underdeveloped)

- [ ] Poor balance and coordination
- [ ] Difficulty paying attention
- [ ] Experiences motion sickness
- [ ] Poor handwriting

Interhemispheric Integration

- [ ] Difficulty understanding direction
- [ ] Difficulty with reading
- [ ] Lack of crawling
- [ ] Weak suckle in infancy
- [ ] Immature dressing skills
- [ ] Difficulty with learning to swim, ride a bike
- [ ] Difficulty with organizational skills
- [ ] Impulsive
- [ ] Diminished concept of consequences

Underactive Right Hemisphere

- [ ] Poor spatial orientation
- [ ] Inappropriate social behavior
- [ ] Cannot reflect on own mental processes
- [ ] Poor nonverbal communication skills
- [ ] Poor attention
- [ ] Impulsivity
- [ ] Difficulty remembering what he/she just read
- [ ] Difficulty with math
- [ ] Eczema
- [ ] Allergies
- [ ] Asthma

Underactive Left Hemisphere

- [ ] Poor reading
- [ ] Delayed speech
- [ ] Poor auditory processing
- [ ] Poor object identification
- [ ] Poor verbal communication skills
- [ ] Depression
- [ ] Unable to write thoughts down
- [ ] Poor motivation

FINANCIAL POLICIES AND TERMS OF ACCEPTANCE OF CARE

It is important for each patient to understand both the objectives and methods of chiropractic care to prevent any confusion or problems in the future. Please take time to review the information below.

Adjustment: An adjustment is the specific application of forces and physiotherapy to facilitate the reduction or correction of spinal misalignment (subluxation).

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes the alteration of both muscle and nerve function. This will interfere with the transmission of nerve impulses which can cause the lessening of the body's ability to function properly.

Our office does not diagnose or treat any diseases or conditions other than Vertebral Subluxation. However, if during the course of an examination we find a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend you seek out the services of your primary care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding the treatment prescribed by others.

All visit charges are payable when services are rendered. Healing Hands Family Chiropractic requires a courtesy call of giving at least 24 hours notice in the event you cannot keep your scheduled appointment. If we do not receive notification of a cancellation of your scheduled appointment within the 24 hour notice, your appointment will be considered a NO SHOW. We reserve the right to charge the full amount of the missed appointment. It is also our policy that appointments remain punctual; you will be given 10 minute after the start of your scheduled appointment before you are considered a NO SHOW. Healing Hands Family Chiropractic also reserves the right to reschedule any appointments where the patient shows up after the 10 minute start of their appointment and you will be charged the full amount of the missed appointment.

We also offer multiple ways to pay including cash, check or credit card. Please be aware that if you choose to pay by credit or debit card, there will be an additional 3% convenience fee for all transactions.

I (please print)_____ have read and fully understand the above Policies and Terms of Acceptance, and hereby grant permission to receive chiropractic services.

Patient signature: _____
Date:_____

AUTHORIZATION AND CONSENT TO EVALUATE AND TREAT A MINOR

By signing this form, I understand that all services are to be paid in full at time of service, unless other arrangements have been made and agreed upon in writing. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, strains, bruising and generalized feelings of stiffness and/or soreness. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my child's best interest.

By signing below, I agree to the above and allow the doctor(s) at Healing Hands Family Chiropractic to perform such treatment on my child. This consent will cover the entire course of my child's treatment.

I hereby authorize the doctors at Healing Hands Family Chiropractic to administer chiropractic care, to work with my child's condition through the use of adjustments and procedures the doctor(s) deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, all fees for professional services rendered will be immediately due and payable.

I (print name)_____ being the legal parent or guardian

of (child's name)_____ have read and fully understand the above **AUTHORIZATION AND CONSENT TO EVALUATE AND TREAT A MINOR**, and hereby grant permission for my child to receive chiropractic services.

Parent or Guardian Signature:_____Date:_____

PRIVACY PRACTICES

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health actions; information regarding victims of abuse; neglect or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donation purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Healing Hands Family Chiropractic will only use or disclose PHI at any time when requested but actions taken prior to revocation are excluded. If authorization is a condition of obtaining insurance coverage and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his/her personal representative. It should include: the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

I (print name)_____ acknowledge, understand and agree to the Privacy Practices of Healing Hands Family Chiropractic.

Patient Signature:_____Date:_____