



Blue Hills Chiropractic New Patient Form Birth - 24 Months Old

1356 2nd Ave., Cumberland
715.822.2500

11 E Marshall St., Rice Lake
715.475.1700

Child's Name: _____ Date: _____ Referred By: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Date of Birth: _____ Age: _____ Gender: _____ Social Security: _____
 Mother's Name: _____ Mother's Cell: _____ Work Phone: _____
 Father's Name: _____ Father's Cell: _____ Work Phone: _____
 List Ages of Other Children in Family: _____
 Pediatrician's Name: _____ Clinic Name: _____
 When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here? Y N
 Primary Insurance: _____ Policy #: _____
 Policy Holder's Name: _____ Policy Holder's Birth Date: _____
 Policy Holder's Employer: _____

Labor & Delivery

Third Trimester Presentation: Vertex _____ Breech _____ Transverse _____ Face/Brow _____
 Type of Birth: Normal Vaginal _____ Forceps _____ Cesarean _____ Suction Cap/Vacuum _____
 Location: Home _____ Birthing Center _____ Hospital _____ # Hours in Labor: _____ Pushed for: _____ min.
 Problems during pregnancy: _____
 Problems during labor/delivery: _____
 Were any medications administered at birth? _____
 Apgar Scores: _____ At the time of birth, was the child: jaundice (yellow)? Y N Cyanosis (blue)? Y N
 Birth weight: _____ Birth Height: _____ Current weight: _____
 Did the mother use any cigarettes, alcohol, or medications during pregnancy? Y N
 Congenital Anomalies/Defects? Y N If yes, please explain: _____

Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

- | | | |
|-----------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Measles, Mumps | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Eczema/Skin problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Frequent Colds/Sore throat | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Emotional Problems |

Please list any medications or supplements your child is currently on: _____

Number of doses of antibiotics your child has taken in his/her history: _____

Has your child ever suffered the following spinal traumas?

- | | | |
|---------------------------------------------------|-------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall of skateboard or skates |
| <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from highchair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Other: _____ |

Date of last visit to pediatrician: _____ Purpose of visit: _____

Y N Has your child ever been treated on an emergency basis? _____

Y N Did you choose to vaccinate your child? If yes, which vaccines? _____

At what age did your child:

- | | | | |
|-------------------------------------------|-------------------------------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Respond to Sound | <input type="checkbox"/> Follow an object with his/her eyes | <input type="checkbox"/> Hold head up | |
| <input type="checkbox"/> Sit alone | <input type="checkbox"/> Crawl | <input type="checkbox"/> Stand | <input type="checkbox"/> Walk alone |

The following questions are designed to allow the doctor to provide a detailed evaluation of your child. If a question is not relevant to your child's age, please put "N/A"

Y N How many hours does your baby sleep between feeds? During day _____ At night _____

Y N Does your child go to sleep easily? _____

Y N Does child have a preferred sleeping position? _____

Y N Does child cry if you change this sleeping position? _____

Y N Does your child have any difficulties feeding? _____

Y N Is baby being breast fed? If no, for how long was baby breast fed? _____ Weeks/months

Y N Does baby have a one sided breast feeding preference? Preferred breast Left / Right

Y N Is your child formula fed? Which formula or other milk source? _____

Y N Does baby frequently spit up after feeding? _____

Y N Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Y N Does your child have any food allergies? _____

Y N Does your child cry a lot? For how many hours each day? _____

Y N Does baby pass a lot of intestinal gas? _____

Y N Does baby have a preferred head position? _____

Y N Does baby frequently arch his/her head and neck backwards? _____

Y N Does baby cry or become irritable during a diaper change? _____

Y N Does your child refuse to make eye contact? _____

How many servings of dairy does your child get a day? _____ How many oz of water? _____

Do you have any other concerns you want to discuss? _____

Y N Has your child ever received chiropractic care? If yes, who? _____

What were the results? _____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Child's Name: _____

Guardian Signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June, 1993) Estimate that incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort. Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment testing and evaluation are performed carefully to minimize risk. Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Child's Name: _____

Guardian Signature: _____ **Date:** _____

Authorization & Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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 HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Child's Name: _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

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 situation 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.

I have read and understand the 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.

Printed Child's Name: _____

Patient/Guardian Signature: _____ Date: _____