

# New England Chiropractic

## Pediatric Patient Introduction

Child's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Birth Weight \_\_\_\_\_ Current Weight \_\_\_\_\_

Sex \_\_\_\_\_ No. of Siblings \_\_\_\_\_ Birth Length \_\_\_\_\_ Current Length \_\_\_\_\_

Type of Birth: Normal Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Breech \_\_\_\_\_ Cesarean \_\_\_\_\_

Home \_\_\_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_

Problems During Pregnancy \_\_\_\_\_

Problems During Labor/Delivery \_\_\_\_\_

APGAR Scores \_\_\_\_\_ Was there presence at birth of: \_\_\_\_\_ Jaundice (yellow)

\_\_\_\_\_ Cyanosis (blue)

Congenital Anomalies/ Defects \_\_\_\_\_

Infant Feeding: Breast \_\_\_\_\_ Bottle \_\_\_\_\_ Formula \_\_\_\_\_

No. of Hours Sleep per Night \_\_\_\_\_ Quality of Sleep: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Obstetrician/ Midwife \_\_\_\_\_  
NAME LOCATED AT

Pediatrician/ Family MD \_\_\_\_\_  
NAME LOCATED AT

Date of Last Visit to MD \_\_\_\_\_ Purpose \_\_\_\_\_

Immunization History \_\_\_\_\_

Purpose of this Appointment \_\_\_\_\_

Has Your Child Ever Been Treated on an Emergency Basis? \_\_\_\_\_

Describe \_\_\_\_\_

### AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTORS TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (Upon approval of parent or guardian).

Signed \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

Date \_\_\_\_\_ Signature \_\_\_\_\_

New England Chiropractic  
Pediatric Case History

PREGNANCY HISTORY

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DELIVERY / BIRTH HISTORY

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DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD...

Respond to Sound _____	Crawl _____
Follow an Object with his/her Eyes _____	Stand _____
Hold Head Up _____	Walk Alone _____
Sit Alone _____	

CHILDHOOD DISEASES

Chicken Pox _____	Rubella _____
Mumps _____	Rubeola _____
Measles _____	Whooping cough _____
Other _____	

HAS THIS CHILD EVER SUFFERED FROM:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Backache	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic Earaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Colds/ Flu
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies
<input type="checkbox"/> Neuritis	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Constipation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Sugar Concentration	<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscle Jerking
<input type="checkbox"/> Fainting	<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Ruptures / Hernias
<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Leg Problems	<input type="checkbox"/> "Growing Pains"
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Other _____

PRESENT HISTORY

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SURGERY: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ACCIDENTS: \_\_\_\_\_

FAMILY HISTORY: \_\_\_\_\_

# NEW ENGLAND CHIROPRACTIC

*“Your Family Wellness Team”*

KELLY LARSON-BRUNNER D.C.

WARREN MUNGER LAIN D.C.

**1. You have the right to inspect and/or copy your health information** for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by the law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you would like further information or have a complaint about our privacy policies and practices please contact: Dr. Lain or Dr. Kelly.

**2. It is the practice of this office to provide chiropractic care in an “open adjusting” environment.** “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

**3. It is our desire for our staff to use your name, address, E-mail and/or telephone number for the purpose of contacting you** to advise you about health related meetings, workshops, and products. We may also call to remind you of scheduled appointments, re-evaluations, appointment related issues, or other special events (birthdays, functions, etc.)

The use of this information and format of “open adjusting” is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the doctors or on your relationship with our staff.

**4. Your signature indicates your authorization of this activity.**

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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 procedures to be completed.