Unity CHIROPRACTIC & WELLNESS CENTER

New Infant/Pediatric Patient Intake Form

Name:		**Birthdate:**
Address:		**Mother's Name:**
Father's Name:		**Email address:**
Home/work phone:		**Mother's & Father's Cellphone:**
Referred by:		
Age:	**Birth Weight:**	**Birth Length:**
Current Weight:	**Current Length:**	**Number of siblings:**
Third Trimester Presentation: Vertex _____ Breech _____ Transverse _____ Face/Brow_____		**Type of Birth: Normal Vaginal _____ Forceps _____ Cesarean _____ Suction Cap or Vacuum _____**
Birth Assisted by: Pitosin_____ Medications_____ Induced _____		**Location of Birth: Home _____ Birthing Center _____ Hospital _____**
Delivery/Birth History:		
Any Latching Issues:		**Does your Child Breathe Through Their Mouth?**

Initial: _____

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Problems During Pregnancy:	**Problems During Labor/Delivery:**
Apgar Score:	**Congenital Anomalies/Defects? If yes please explain:**
Was There Presence at Birth of: Jaundice _____ Cyanosis_____	**Infant Feeding: Breast _____ Bottle _____ If Bottle, Which Formula? _____**
Number of Hours of Sleep Per Night:	**Quality of Sleep: Good _____ Fair _____ Poor _____**
Obstetrician/Midwife:	**Any Allergies:**
Pediatrician/Family MD:	**Date of Last Visit:**
Purpose of Last Visit:	**Immunization History:**
Number of Doses of Antibiotics Your Child has Taken: During the Past Six Month: _____ Lifetime _____	**Previous Chiropractor:**
Date of Last Chiropractic Visit:	**Purpose:**
Has You Child Ever Been Treated on an Emergency Basis_____ If Yes Please Explain:	**Purpose of This Appointment:**
At What Age Did Child: Respond to Sound_____ Follow an Object with Their Eyes_____ Hold Head Up _____ Sit Alone _____ Crawl _____ Stand ____ Walk Alone _____	**At What Age, If Ever, Did This Child Suffer from the Following Conditions? Chickenpox _____ Mumps _____ Measles _____ Rubella _____ Rubeola _____ Whooping Cough _____ Other: _____**

Initial: _____

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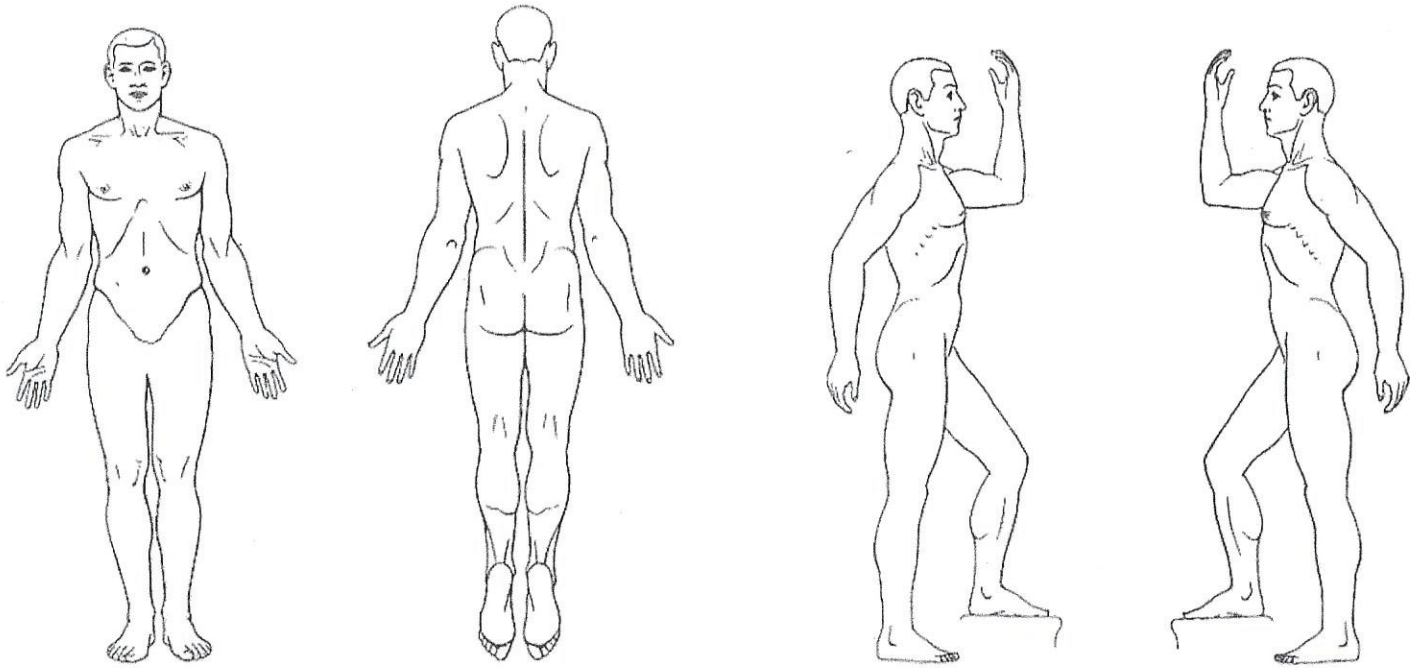
Current Complaints

Patient Name: _____ Date: _____

Please mark on the body where your discomfort is, using:
A = Aching
B = Burning
S = Stabbing
N = Numbness.
P = Pins and Needles



Initial: _____

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Medical History

Past Conditions: (Accidents, Injuries, Sprains/Strains, etc.)	Date/Year

Past Treatments: (Chiropractic, Acupuncture, Massage, etc.)	Date/Year

Habit:	Frequency:
Bowel Movement	
Pacifier Use	
Thumb sucking	
Mouth Breathing	
Snoring	
Sleep	
Appetite	
Soda	
Water	
Exercise	
Sugar/ Sweets	
Artificial Sweeteners	

Vitamins/Supplements:	Dosage

Family History: (heart disease, cancer, diabetes, arthritis, etc.)

Surgeries:	Date/Year

Medications: (Over the Counter & Prescription)	Dosage

Allergies:

Initial: _____

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Has This Child Ever Suffered From:

☐ Headaches ☐ Orthopedic Problems ☐ Digestive Disorders ☐ Dizziness

☐ Behavioral Problems ☐ Neck Problems ☐ Poor Appetite ☐ ADD/ADHD

☐ Fainting ☐ Arm Problems ☐ Stomach Aches ☐ Ruptures/Hernia

☐ Seizures/Convulsions ☐ Leg Problems ☐ Reflux ☐ Muscle Pain

☐ Heart Trouble ☐ Joint Problems ☐ Constipation ☐ Growing Pains

☐ Chronic Earaches ☐ Backaches ☐ Diarrhea ☐ Sinus Trouble

☐ Poor Posture ☐ Diabetes ☐ Asthma ☐ Scoliosis

☐ Hypertension ☐ Colds/Flu ☐ Walking Trouble ☐ Anemia

☐ Colic ☐ Broken Bones ☐ Bed Wetting ☐ Other _____

Has This Child Ever Suffered the Following Spinal Traumas?

☐ Fall in Baby Walker ☐ Fall From Bed or Couch ☐ Fall off Skateboard or Skates

☐ Fall From Crib ☐ Fall Off Swing ☐ Fall Off Bicycle

☐ Fall From Highchair ☐ Fall Off Slide ☐ Fall Down Stairs

☐ Fall From Changing Table ☐ Fall Off Monkey Bars

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain _____

_____

_____

Has this child ever sustained injuries in an auto accident? _____ If yes, please explain _____

_____

_____

Present History: _____

_____

_____

_____

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

General Care and Treatment Consent

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment. The consent will remain fully effective until it is revoked in writing. You have the right at any time, to discontinue services.

You have the right to discuss the treatment plan with your physician including the purpose, potential risks, and benefits of any test(s) ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request, of the practitioners her at Unity Chiropractic and Wellness Center (Doctor of Chiropractic, Massage Therapist, Acupuncturists, or Licensed Counselor), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

By my signature below I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Cancellation Policy/No Show Policy for Appointments

Here at Unity Chiropractic and Wellness Center our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of care.

1. **Cancellation/No Show Policy for Chiropractic/Acupuncture/Massage Appointments**

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
- A "no show" is someone who misses an appointment without canceling it within a 24-hour working day in advance. No shows inconvenience those individuals who need access to care in a timely manner.

How to Cancel Your Appointment

- If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.
- To cancel an appointment, please call our office 8:30 am through 6 pm at 503-747-3388 to speak with the front desk or leave a voicemail during the hours we are closed.

2. **Scheduled Appointments**

- We understand that delays can happen, however, we must try to keep other patients and our staff on time. If you are running late, please notify the office.

If a patient is 10 minutes past their scheduled time, we may have to reschedule your appointment

The following are charges for services in the office:

Same Day Appointment Cancellation/No show for Chiropractic or Massage: $60
Same Day Appointment Cancellation/No Show for Acupuncture: $50

By my signature below I understand that I will be charged for appointments I cancel in less than 24 hours or do not show up for

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Consent to Use and Disclose Protected Health Information

Here at Unity Chiropractic and Wellness Center we take protecting your privacy very serious. While the law requires us to give you this disclosure please know that we have, and we always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

Notice of Treatment in Open or Common Areas

Private areas are available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information for reasons stated above.

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____