Whom may we thank for referring you to this office → _____

PEDIATRIC APPLICATION FOR CARE AT NEW JOURNEY CHIROPRACTIC

Today's Date: _____

Patient Information

Child's Name: _____Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Parent/ Guardian name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Siblings Names and Ages _____

Previous Chiropractic Care ☐ No ☐ Yes

If Yes, what was their reason for visit? _____

Name of Previous Chiropractor: _____

How long were you under care: _____ What were the results? _____

Emergency Contact

Name _____ Relationship to child : _____

Phone Number_____ Alternate Phone Number:_____

Family Doctor

Name_____ Clinic Name_____

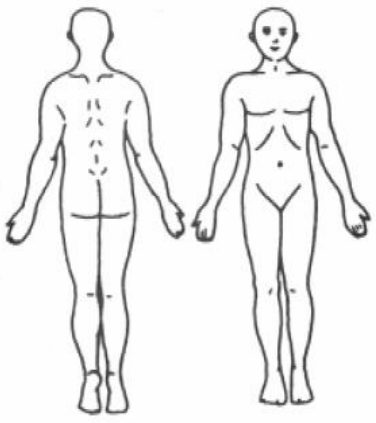
When where they last seen _____Reason for visit_____

Why have you decided to have your child evaluated by a Chiropractor?

☐ He/ She is continuing care from another chiropractor
☐ Recently had my spine checked and understand the value in getting my child checked
☐ He/ She has a specific condition and I've learned that chiropractic may be able to help
☐ Want to help support my child's immune function
☐ Have concerns about his/her health and I'm looking for answers

What is your specific concern(s) that brings you in to our office today? _____
Does your child appear to be in pain or discomfort? ☐No ☐Yes
How long has your child been experiencing this? _____
Is it getting better, worse or staying the same? _____ Was the onset sudden or gradual? _____
Have you seen other health professionals regarding this complaint?
☐No ☐Yes, whom? _____
What treatment(s) did they use? _____
Has your child taken medication for this complaint? . . . . . .☐No ☐Yes _____
Has your child ever experienced this complain before? . . . . . ☐No ☐Yes _____
Did they receive any treatment at the time? . . . . . ☐No ☐Yes _____
Has your child had x-rays in relation to the current complaint? . . . . . .☐No ☐Yes _____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your child's symptoms? _____

What makes your child's symptoms feel worse? _____

LIST RESTRICTED ACTIVITY *(Jumping, Running, Walking)* _____

CURRENT ACTIVITY LEVEL _____

USUAL ACTIVITY LEVEL _____

What additional signals has your child been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
		Asthma			Frequent Diarrhea			Failure to Thrive / Slow Weight Gain
		Respiratory Tract Infections			Constipation			Slow or Absent Reflexes
		Sinus Problems			Flatulence			Asymmetrical Crawling or Gait
		Ear Infections			Headaches/Migraines			Weight Challenges
		Tonsillitis			Neck Pain			Bed Wetting
		Strep Throat			Torticollis/Head Tilt			Sleep Problems
		Frequent cols/Croup			Trouble Feeding on One Side			Night Terrors
		Recurrent Fevers			Back Pain			Tip Toe Walking
		Eczema			Growing Pains			Regression of Milestones
		Rashes			Scoliosis			Seizures
		Allergies			Red, Swollen, Painful Joint			Tremors / Shaking
		Food Sensitivities			Colic			ADD / ADHD
		Digestive Problems			Frequent Crying Spells			Autism / PPD

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown
Any Maternal Illness during pregnancy: ☐No ☐Yes *(brief description)* _____
Number of previous pregnancies _____
Complications during pregnancy: ☐No ☐Yes *(brief description)* _____
Ultrasounds during pregnancy: ☐No ☐Yes, if so, how many? _____
Medications during pregnancy: ☐No ☐Yes _____
If so, which ones and how often? *(Include OTC)*: _____
Exposure to alcohol, cigarettes or secondhand smoke during pregnancy: ☐No ☐Yes _____

Birth Experience

Location of Birth: ☐Home ☐Hospital ☐Birthing Center ☐Other _____
Birth Attendants: ☐Doula ☐Midwife ☐GP ☐OB ☐Other_____
Medications during labor / delivery *(including IV antibiotics)* ☐No ☐Yes _____
Was Pitocin used to induce / speed up labor? ☐No ☐Yes
Were your membranes ruptured by a medical professional? ☐No ☐Yes

Birth Experience (continued)

Was your child at any time during your pregnancy in an intra-uterine constraining position? ☐No ☐Yes ☐Unsure
If yes, please describe: ☐Breech ☐Transverse ☐Face / Brow presentation
Was your delivery vaginal or C-section? _____ If it was C-section, was it planned or emergency? _____
If it was vaginal, was the baby presented: ☐Head ☐Breech *(circle one)* Face or Forehead Presentation
Were any of the following interventions used during delivery? ☐Forceps ☐Vacuum Extraction ☐Other _____
Were there any complication during delivery? ☐No ☐Yes
If yes, please specify: _____
How long was the labor from first regular contractions to the birth? _____ Hours
How long was the second stage (the pushing phase) of the labor? _____ Hours
Was the baby born with any purple markings / bruising on their face or head? ☐No ☐Yes
Did your baby have jaundice? ☐No ☐Yes, what treatments were used? _____
Any concerns about misshapen head at birth? ☐No ☐Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ___ w___ d / Birth weight: ___ lbs___ oz / Birth Length ____ inches
If known, APGAR scores at: 1 minutes _____ / 10 5 minutes _____ / 10
Was the baby ever administered to Neonatal Intensive Care? ☐No ☐Yes
If yes, for how long and why? _____
Were there any medication/vaccine(s) given to the baby at birth? ☐No ☐Yes ☐Unsure
If yes, what medication and why? _____
Was your child exclusively breastfed? ☐No ☐Yes _____ months
Did your child have any tongue ties or prefer nursing to one side? ☐No ☐Yes _____
Was your child breastfed + formula fed? ☐No ☐Yes _____ months
Was your child formula fed? ☐No ☐Yes _____ months Brand _____Was it imported formula? ☐No ☐Yes
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐No ☐Yes
What age did you introduce solid foods to your child? _____ months
Did you introduce cereal or grains within your child's first year? ☐No ☐Yes
Did/Do you practice attachment parenting methods: ☐No ☐Yes
(i.e. co-sleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding, etc.)
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats, etc?
☐No ☐Yes, if so, which ones? _____

Physical Traumas

Has your child ever fallen from any high places? . . . . . ☐No ☐Yes _____
Has your child ever been involved in a motor vehicle accident or near miss? . . . . .☐No ☐Yes _____
Has your child been seen on an emergency basis? . . . . . .☐No ☐Yes _____
Has your child broken any bones? . . . . . .☐No ☐Yes _____
Has your child had any previous hospitalizations? . . . . . ☐No ☐Yes _____
Has your child had any previous surgeries? . . . . . .☐No ☐Yes _____
Does your child spend time using a tablet, computer or video games? . . ☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child watch tv?. . . . . .☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child exercise? . . . . . .☐No ☐Daily ☐Weekly ☐Seasonally
Does your child play contact sports?. . . . . .☐No ☐Daily ☐Weekly ☐Seasonally
Does your child sleep on their . . . . . .☐Back ☐Belly ☐Sides (both, right, left)
Does your child carry a back pack?. . . . . .☐ No ☐Yes
Does it weigh less than 15% of their body weight? . . . . . ☐ No ☐Yes ☐Unsure
Do they wear their back pack on 2 shoulders? . . . . . .☐No ☐Yes ☐Sometimes
Does your child show excessive or uneven shoe wear? . . . . . .☐No ☐Yes
Does your child wear custom orthotics? ☐No ☐Yes, for what purpose? _____

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule
Reason for vaccination: ☐Informed decision ☐Didn't know I had a choice ☐It was recommended
Reaction(s) to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue ☐Prolonged Cry ☐Seizures ☐Developmental Regression ☐Other_____
Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)
Has your child been exposed to antibiotics? ☐No ☐Yes
If yes, how many doses in the past 6 months? _____ Reason _____
Were probiotics used at the same time as the antibiotics? ☐No ☐Yes
Has your child been exposed to medications, including OTC? ☐No ☐Yes
If yes, which ones? _____
If yes, how many doses in the past 6 months _____ Reason _____
How many glasses of water/day does your child have? . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and soda/day does your child have? . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Does your child eat gluten? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ☐No ☐Yes If yes, which ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐No ☐Yes
Does your child follow any other dietary restrictions? ☐No ☐Yes _____
Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes _____
Is your child exposed to secondhand smoke? ☐No ☐Yes _____
Does your child take a probiotic daily? ☐No ☐Yes _____ CFU's/day
Does your child take vitamin D3 daily? ☐No ☐Yes _____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐No ☐Yes _____ mg/day ☐Capsule ☐Liquid
Other supplements or homeopathic remedies? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?
Intellectually: ☐Yes ☐No _____
Emotionally: ☐Yes ☐No _____
Physically: ☐Yes ☐No _____
What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this is healthy growth is nervous system functioning free from interference called subluxations.

You've taken an important step in your child's future through a chiropractic evaluation. ☺

Consent to Evaluation of a Minor Child

I _____ being parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)

Hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

_____ _____
Consenting Adult's Signature Date

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL Additional Items:
1) May we confirm your appointments by email, text or phone? Yes No
2) May we leave a message on your answering device at home or cell phone? Yes No
3) May we discuss your condition with any members of your family? Yes No
If yes, provide names: _____
4) We utilize open adjusting bays. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to hold private conversations in a private room if requested.
Are you comfortable being treated in an open bay? Yes No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation, it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

New Journey Chiropractic Appointment Policy

Consistency The Doctor's recommendations for your appointment consistency is directly related to the diagnosed condition of your spine. Our goal is to NOT ONLY relieve your expressed concerns but ultimately eliminate any subluxations that stop the nerves from functioning properly. Our desire is to prevent any further conditions/diseases from developing in the future which may inhibit you to do what you love with those you love. When your X-RAYS reveal a corrected spine, we know we both have accomplished that objective. We will always support you in staying committed to your health by guiding you to stay on track with your appointments as you build momentum with each adjustment. Cancelling appointments isn't an option. We ask you to reschedule any missed appointments immediately.

Walk-In's We are an Appointment Only practice. We are not able to accommodate Walk-In's. To make an appointment call 386-236-8085 or use our Phone App SKED.life for available appointment times.

Out of Town When you leave to go out of town, you'll need to "bulk up" your appointments before & after to make up for the missed time here in the office. Take your Home Care Therapy with you to utilize each day to stabilize the spine since no adjustments are received while you are away. This will continue the momentum & defer any regression of your spine.

Early or Late We understand you may be early or late for your appointment. However, we must keep the other patients and doctor on time.

If you have arrived "EARLY" please be respectful of others and wait until your "actual" scheduled time.

*If you are "LATE" (10 min past your appointment) we will have to reschedule the adjustment for the next available time.

No Call/No Show We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't show up at all, you may be preventing another patient from getting much needed care. When the schedule looks "full" and we turn someone away, we could have indeed helped them if we had known your appointment was available. We require you to contact us 1 hour before your appt to avoid any fees and allow others to schedule in your time slot.

1st No Call/No Show - Verbal warning 2nd No Call/ No Show -A $25 fee is charged to be paid before receiving your next adjustment and for every recurring No Call/No Show afterwards. Effective April 1, 2019.

_____ _____ _____

Print Name **Signature** **Date**