

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? _____

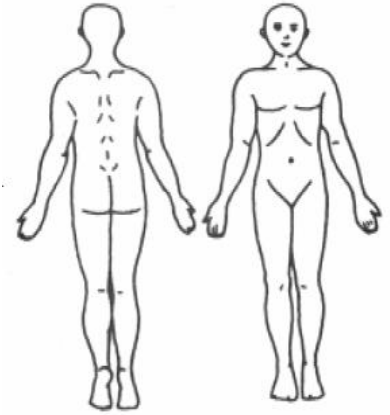
Has your child taken medication for this complaint? No Yes _____

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 = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



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 colts/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 constricting 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 Went 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

OUR OFFICE POLICIES

Welcome to New Journey Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies," if you have any questions, or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interest to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient. Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

- YOUR CARE** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at New Journey Chiropractic is rendered primarily to minimize and reduce subluxations, which are major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.
- FIRST THINGS FIRST** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do, in addition to being adjusted, to maintain their health for a lifetime.
- PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first appointment, you will be scheduled for a 'Doctors Report of Findings.' The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

New Journey Chiropractic's NOTICE REGARDING OFFICE POLICIES

I hereby acknowledge receipt of the practice's "Office Policies." I understand that any concerns regarding these policies as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient or Authorized person's Signature

____/____/____  *Witness Initials*
Date

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 *The Scheduling App* 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