BALANCED LIFE
CHIROPRACTIC

Newborn Health Questionnaire (Ages 0-1 year)

Name of Child: _____Date: _____Birthdate: _____

☐ Male ☐ Female Name of Parents: _____

Address: _____
Residence and mailing City State Zip Code

Best Contact Number:(_____)_____ Email Address: _____

Who may we thank for referring you to our office? _____

Pregnancy History

Any fertility issues? Y / N If yes, please describe: _____

Did mother smoke? Y / N If yes, how many per week: _____

Did mother drink? Y / N If yes, how many per week: _____

Did mother exercise? Y / N If yes, please describe: _____

Was mother ill? Y / N If yes, please describe: _____

Any ultrasounds? Y / N If yes, please describe: _____

Please explain any notable episodes of mental or physical stress during pregnancy_____

_____

Birth and Labor History

Place of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth care provider ☐ OB/GYN ☐ Midwife ☐ Doula

Please check all that apply in regards to your labor and the birth process for this child:

___ Cesarean Section
___ Abnormal/Breech presentation
___ Pain medication
___ Epidural
___ Lack of fetal decent
___ Long and/or difficult labor
___ Antibiotics administered
___ Forceps
___ Suction device
___ Pitocin administered
___ Fetal Distress
___ Cord around neck
___ Labor induced
___ Lack of progression
___ Rupture of membranes

Post Natal History

Please check all that apply for your baby as a newborn:

___ Resuscitation/Oxygen required
___ Prolonged cranial distortion
___ Low APGAR score
___ Antibiotic administered
___ Premature
___ Jaundice
___ Meconium aspiration/stomach
___ Circumcised
___ Poor sleeping
___ Colic
___ Failure to thrive
_____ Difficulty nursing/latching/sucking

General Health

Diet History:

Was your baby breastfed? ☐ Exclusively ☐ Previously ☐ Breastfed and Formula fed

Formula Details (if applicable): ☐ Milk ☐ Soy ☐ Organic ☐ Homemade ☐ Special

_____

Supplements your baby takes directly: _____

Supplements mom takes if nursing: _____

Vaccination History: ☐ Up-to-date ☐ Partial ☐ Delaying ☐ Conscientious Objector

☐ Concerned/Unknown ☐ Vaccine Reactions: _____

Infant Health History

✓ all that apply for your infant:

___ Abnormal tone
___ High pitched crying
___ Weight loss
___ Poor eye control
___ Difficulty swallowing
___ Breathing problems
___ Bruises
___ Swelling of muscles/joints
___ Meningitis
___ Tremor
___ Cold hands/feet
___ Serious infection
___ Diarrhea
___ Vomiting
___ Abnormal growth patterns
___ Food intolerance

___Recent trauma
___ Poor sleep
___Excessive tearing
___ Poor hearing
___ Tongue tied
___ Skin rash/eczema
___ Scars
___ Limited range of motion
___ Neurological Ticks
___ Uncoordinated movements
___ Extremity swelling
___ Allergy
___ Bloating
___ Stomach Tenderness
___ Lack of nursing/eating
___ Excessive sweating

___ Irritability
___ Poor weight gain
___ Conjunctivitis
___Ear aches/discharge
___ Diaper Rash
___Skin masses/bumps
___ Fall from 2+ ft
___ Convulsions
___ Cyanosis (blue/purple color)
___ Abnormal heart rhythm
___ Constipation
___ Seizures
___ Scoliosis
___ Excessive spitting-up
___ Pain/difficult urination
___ Other

For Doctor's Use Only

_____

_____

_____

BALANCED LIFE
CHIROPRACTIC

Informed Consent for Chiropractic Care

We encourage and support a shared decision-making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation. A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, nervous system scans, palpation, and/or radiological examination (x-rays). The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but are typically delivered by hand, but may be performed by handheld instrument. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care. Risks associated with chiropractic treatment may include soreness, musculoskeletal sprain/strain, and/or fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. You are being informed of this reported association because a stroke may cause neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Alternative treatments have been explained, including the risks, consequences and effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED. HAVING THIS KNOWLEDGE, I AUTHORIZE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Print Name Date

_____

Signature

Consent for Minor Patient:

I, _____being the parent or legal guardian of _____have read and understand the above Informed Consent and grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

BALANCED LIFE
CHIROPRACTIC

HIPAA Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations 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 of request. You may request to view charges 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 and 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, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

_____ _____

Print Name Date

_____

Signature

Consent for Minor Patient:

I, _____ being the parent or legal guardian of _____

have read and fully understand the above HIPAA Form.

_____ _____

Print Name Date

_____

Signature