



Last Name: _____

PEDIATRIC NEW PATIENT FORM

Date: _____ Social Security # _____

Child's Name:

_____ Last _____ First _____ M.I _____

Address _____

Sex: _____ Male _____ Female Age: _____ Birthdate: _____

Parent/Guardian's Name: _____

Address (if different from above)

E-mail (please provide for communication purposes) _____

Cell Phone: _____ Home Phone: _____

Preferred method of communication: (Check one) Email ___ Text ___ Phone _____

How did you find out about our clinic? _____

Child's School _____

Emergency Contact: _____ Relationship: _____ Phone _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of Accident: Auto ___ Sports ___ Home ___ Other ___

Are you currently pursuing an accident related Claim? Yes ___ No ___

INSURANCE INFORMATION (for accident related claims only):

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Julie Paul, DC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of above signature Relationship to Patient

Please indicate the main reason(s) your child is seeing us today and age of onset:

Other Treatments previously tried for these conditions: _____

Does this disrupt your child in any of the following areas: play school sleep eating peer interactions
Other: _____

At what frequency: daily weekly monthly

Does affect you and/or your family's home life: daily weekly monthly

Please describe: _____

Please describe any home or school situations that may be causing stress to your child:

Has your child been vaccinated? Yes No On which schedule: Never Routine Extended

Did your child experience any adverse reactions that you noticed after vaccination? Yes No

Please describe: _____

Please describe your child's pregnancy and birth: home birth midwifery center hospital
premature normal gestational age back labor prolonged delivery rapid delivery induced delivery
epidural Pitocin/other stimulants C-Section Vaginal Delivery Suction Forceps Fetal Skull Monitor
Hours in Labor _____

Other Comments: _____

Other Stressful situations during the pregnancy (for you or the family)

Has your child met major developmental milestones for sitting, crawling, standing, and walking? Yes No

If NO, please explain: _____

Does your child appear to interact normally with you and your family? Yes No

How many hours per day does your child do the following:

Play _____ Sit _____ Screen Time (computer/tv/phone,etc) _____

Is your child a "picky eater"? Yes No

What are your child's favorite foods? _____

Allergies: _____

What are 3 things you love about your child or his/her personality:

1) _____ 2) _____ 3) _____

What are 3 of your child's favorite activities or interests:

1) _____ 2) _____ 3) _____

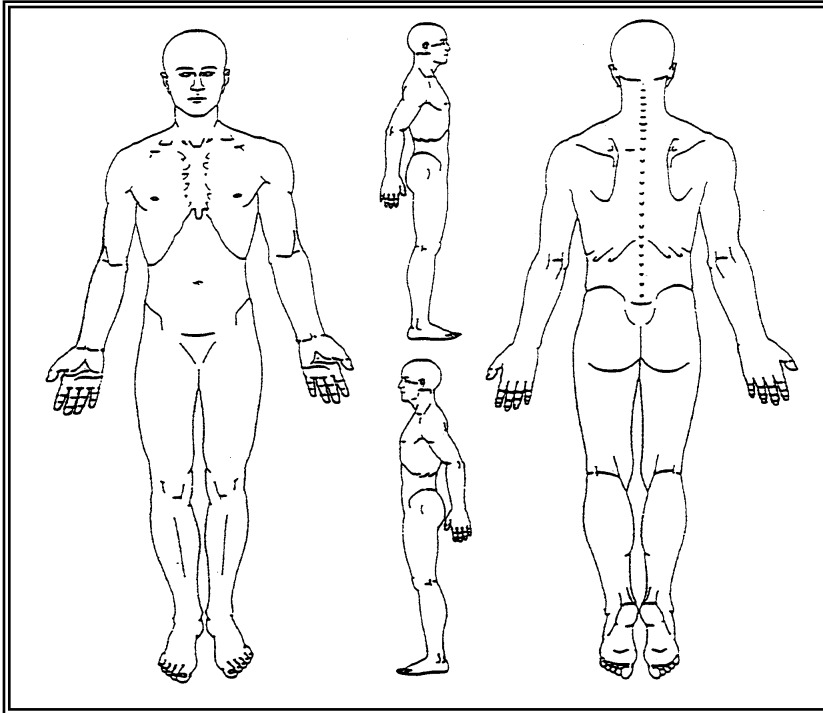
Is there anything that would help your child them relax or be more comfortable under our care:

Is there anything that we should avoid while your child is under our care (loud noises, firm touch, fears, etc):

Other important things to know about your child: _____

If your child is seeing us for a pain/injury issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX // // // // // // O O O O O O O O S S S S S - - - - -
DULL/ACHY SHARP/STABBING NUMBNESS/TINGLING STIFF/TIGHT BURNING



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

- 0 = No Pain. No Discomfort
- 1 = Minimal Discomfort. Minor stiffness or tightness.
- 2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain. More than just sore. Uncomfortable.
- 4 = Mild Pain. Noticeable pain but tolerable.
- 5 = Moderate Pain. Aggravating. Still allows movement.
- 6 = Strong Pain. Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain. Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
- 9 = Severe Pain. Brings tears. Almost impossible to move.
- 10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Sources of Physiological Stress:

Emotional/Mental	Physical Trauma/Falls/Accidents	Toxins/Chemical Exposure
<input type="checkbox"/> school related stress	<input type="checkbox"/> birth injury/premature	<input type="checkbox"/> harsh chemical cleaners
<input type="checkbox"/> home related/kids/family	<input type="checkbox"/> vehicle accidents: yr(s) _____	<input type="checkbox"/> tobacco/alcohol/drug exposure
<input type="checkbox"/> relational	<input type="checkbox"/> sports injuries	<input type="checkbox"/> pets and allergies
<input type="checkbox"/> psychological	<input type="checkbox"/> childhood injuries	<input type="checkbox"/> environmental/building toxins
<input type="checkbox"/> spiritual	<input type="checkbox"/> virus/illness/disease	<input type="checkbox"/> medications _____ yrs
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____

Medical Symptoms Questionnaire

Patient Name _____

Date _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

Point Scale

- 0 - Never or almost never have the symptom
- 1 - Occasionally have it, effect is not severe
- 2 - Occasionally have it, effect is severe
- 3 - Frequently have it, effect is not severe
- 4 - Frequently have it, effect is severe

HEAD _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia Total _____	ENERGY/ACTIVITY _____ Fatigue, Sluggishness _____ Apathy, Lethargy _____ Hyperactivity _____ Restlessness Total _____	LUNGS _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing Total _____
EYES _____ Watery or Itchy Eyes _____ Swollen, Reddened or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (does not include near or far-sighted) Total _____	WEIGHT _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight Total _____	HEART _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain Total _____
EARS _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss Total _____	EMOTIONS _____ Mood Swings _____ Anxiety, Fear, Nervousness _____ Anger, Irritability, Aggressiveness _____ Depression Total _____	DIGESTIVE TRACT _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloating Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain Total _____
NOSE _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation Total _____	MIND _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty in Making Decisions _____ Stuttering or Stammering _____ Slurred Speech _____ Learning Disabilities Total _____	OTHER _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge Total _____
MOUTH/THROAT _____ Chronic Coughing _____ Gagging, Frequent Need to Clear Throat _____ Sore Throat, Hoarseness, Loss of Voice _____ Swollen or Discolored Tongue, Gums/Lips _____ Canker Sores Total _____	JOINTS/MUSCLE _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness Total _____	GRAND TOTAL _____
SKIN _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating Total _____	JOINTS/MUSCLE _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness Total _____	GRAND TOTAL _____

Optional Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, x-ray reports/copies, financial/billing information or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- Complete Records
- Care Plan
- Lab Reports
- X-Ray Narrative
- Billing/Financials
- Copy of X-Rays (Subject to a \$20 fee)
- Other (Please Specify) _____

Release my protected health information to the following physician/person/facility/entity (s) and/or those directly associated in my medical care:

Name: _____

Address: _____

City, State & Zip Code: _____

Name: _____

Address: _____

City, State & Zip Code: _____

Signature: _____

Printed Patient Name: _____

Date: _____

Printed Name of Patient's Personal Representative if applicable: _____

(Must have proof of authorization)

Signature of Personal Representative: _____

Payment information for release of X-Ray copies:

Name on Card _____ Billing Address _____

_____ Type of Credit Card _____

Credit Card number _____ Expiration _____

Patient Name _____

Financial Responsibility

Natural Healthcare that includes whole food supplementation, exercise and other remedies are not generally covered by third party payers (insurance companies). Revive Chiropractic provides its services directly to you, not to your insurance company. In certain cases, there may be the opportunity for reimbursement. Our financial policy is that fees are paid at the time of service and when products are provided they can be paid for by cash, check, or credit card. However, if applicable, we will provide you with the proper documentation for your reimbursement needs.

I have read and understood all the above information.

Patient Signature

Date

X-Ray Consent

_____ Check here if you are pregnant or think you may be pregnant at this time.

I hereby give my consent to Revive Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.

I have read and understood all the above information.

Patient Signature

Date

Clinical Summary (a required EMR question)

_____ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to realign your spine. We do many gentle chiropractic techniques, though sometimes you may feel a “click” or “pop” and you may feel movement of the joint. The doctor may request x-rays to be taken if necessary after reviewing your case. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscle soreness, fatigue, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. We primarily do not use adjustments to the neck region that involve twisting that would cause this type of injury. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Informed Consent and Release of Minor to Chiropractic Treatment

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to allow my child to undergo the recommended treatment, and hereby give my consent to allow my child to be treated.

Parent/Guardian Signature

Date

Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to provide you with a complete, detailed disclosure at your request, please understand that we will always respect the privacy of your health information.

I understand that, under the Health Insurance Portability & 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 among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization may need to use my name, address, phone number, e-mail, and clinical records to contact me with appointment reminders, information about treatment alternatives, newsletters, or other health related information that may be of interest to me. I consent to receive communications sent by or on behalf of Revive Chiropractic via regular mail, e-mail, telephone, or fax. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone. By signing this form, I am giving you authorization to contact me with these reminders and information and to leave messages on my answering machine or with individuals at my home or place of employment.

Name _____

Date _____

Acknowledgement of Receipt of Privacy Practices

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature

Date