LANDMARK CHIROPRACTIC Pediatrics

New Practice Member Health Form

Child's Name: _____ Today's Date: _____/_____/_____

Parent's or Guardian's Name(s) _____

Address: _____ City, State, Zip _____

Parent's Cell Phone: _____ Parent's Email: _____

How did you hear about us? _____

Birth Date: _____/_____/_____ Sex: _____ Height: _____ Weight: _____

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

☐ He / She is continuing care from another chiropractor
☐ I have concerns about his/her health and I'm looking for answers
☐ He / She has a specific condition, and I've learned that chiropractic may be able to help
☐ I want to improve my child's immune function/overall wellness

List The Two Primary Health Concerns That Brings Your Child into Our Office:

	Health Concerns List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.						
2.						

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma/Difficulty Breathing	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Low Muscle Tone
☐	☐	Bronchitis & Pneumonia	☐	☐	Gas Pain & Bloating	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear & Sinus Infections	☐	☐	Headaches & Migraines	☐	☐	Tip Toe Walking
☐	☐	Hearing loss	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Swollen Tonsils & Adenoids	☐	☐	Torticollis / Head Tilt	☐	☐	Bladder & Urination Issues
☐	☐	Sore Throat & Strep	☐	☐	Plagiocephaly	☐	☐	Difficulty Sleeping
☐	☐	Chronic Chest colds & Coughs	☐	☐	Back Pain	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Growing Pains/Tight Muscles	☐	☐	Lightheaded & Dizziness
☐	☐	Skin Conditions / Rashes	☐	☐	Weak Ankles & Arches	☐	☐	Balance & Coordination Challenges
☐	☐	Allergies/Autoimmune Challenges	☐	☐	Red, Swollen, Painful Joint	☐	☐	Seizures
☐	☐	Gluten or Lactose Intolerance	☐	☐	Colic & Excessive Crying	☐	☐	Frequent Tantrums & Meltdowns
☐	☐	Frequent Nausea	☐	☐	Difficulty Latching / Nursing	☐	☐	ADD / ADHD
☐	☐	Jaw / Swallowing Issues	☐	☐	Reflux & Excessive Spit Up	☐	☐	Autism
☐	☐	Sensory Food Aversions	☐	☐	Blood Sugar Problems	☐	☐	Vision Issues
☐	☐	Chronic Inflammation	☐	☐	Poor Metabolism/Weight Control	☐	☐	Hearing Issues

Has your child ever seen other Doctors for any of their conditions? ☐ Yes ☐ No

☐Chiropractor ☐ Physical Therapist ☐Medical Doctor ☐Other

Name of the Doctor and when: _____

Please list any drugs/medications/vitamins/herbs/other that your child is currently taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

List your top three health goals for your child:

1.) _____

2.) _____

3.) _____

Activities of Life (Ages 0-2 years)

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their life:

ACTIVITY	**EFFECT**		
Holding Head Up	☐No Effect	☐Limited	☐Unable to Perform
Tummy Time	☐No Effect	☐Limited	☐Unable to Perform
Nursing	☐No Effect	☐Limited	☐Unable to Perform
Sitting Up	☐No Effect	☐Limited	☐Unable to Perform
Crawling	☐No Effect	☐Limited	☐Unable to Perform
Standing Alone	☐No Effect	☐Limited	☐Unable to Perform

Activities of Life (Ages 3-7 years)

Stand	☐No Effect	☐Limited	☐Unable to Perform
Sit	☐No Effect	☐Limited	☐Unable to Perform
Walk	☐No Effect	☐Limited	☐Unable to Perform
Run	☐No Effect	☐Limited	☐Unable to Perform
Exercise/Play	☐No Effect	☐Limited	☐Unable to Perform
Chores	☐No Effect	☐Limited	☐Unable to Perform
Play Sports	☐No Effect	☐Limited	☐Unable to Perform
Read	☐No Effect	☐Limited	☐Unable to Perform
Sleep	☐No Effect	☐Limited	☐Unable to Perform

Pregnancy and Fertility History

Please tell us about the mother's pregnancy of the child being evaluated:

Any fertility issues or fertility treatment? ☐ Yes ☐ No
Please explain: _____

Did the mother smoke or drink? ☐ Yes ☐ No
How many times per week: _____

Did the mother exercise? ☐ Yes ☐ No
How many times per week? _____ What type of exercise? _____

Was the mother ill with any of the following conditions?
☐Gestational Diabetes ☐Preeclampsia ☐Hyperemesis Gravidarum ☐Oligohydramnios

Please explain any episodes of mental, emotional, or physical stress during the pregnancy:
_____

_____

Labor and Delivery History:

Location of Birth: ☐Home ☐Birth Center ☐Hospital

At how many weeks gestation was your child born? _____

Childbirth was: ☐Vaginal Birth ☐Scheduled C-Section ☐Emergency C-Section
If *vagina*l, was the baby presented: ☐Head ☐Face ☐Breech

Was the mother induced? ☐Yes ☐No If yes, please select methods used:
☐Membranes Stripped ☐Foley Balloon ☐Breaking of Water ☐Prostaglandin Gel

Was your child in a constrained position at any time during labor and delivery?
☐Breech ☐Transverse ☐Face / Brow presentation ☐Occiput Posterior

Total hours mother was in labor: _____ Total hours mother was pushing: _____

Was your baby born with any purple markings / bruising on their face or head? ☐Yes ☐No

Any concerns about misshapen head at birth? ☐Yes ☐No

Were any medications administered?
☐Pitocin ☐Epidural or Spinal Block ☐Opioids ☐Other Pain Meds

Were any Interventions used?
☐Episiotomy ☐Forceps ☐Vacuum Extraction ☐Manual Assistance

Were there any complications during delivery? i.e. Wrapped Cord. ☐Yes ☐No
If yes, please specify: _____

Growth and Development History

Was your child ever admitted to the NICU? ☐ Yes ☐ No
If yes, why and for how long? _____

Is / was your child breastfed? ☐ Yes ☐ No **How long?** _____

Any difficulty with breastfeeding? ☐ Yes ☐ No
If yes, please explain. _____

Is there a certain side that is more difficult for them to latch or feed? ☐ Yes ☐ No **If yes, which side?** _____

Is / was your child formula fed? ☐ Yes ☐ No **If yes, at what age?** _____

Did / does your child suffer from colic, reflux, or constipation? ☐ Yes ☐ No
If yes, please explain: _____

Did / does your child frequently arch their neck/back, feel stiff, tighten their belly, or throw their bodies back?
If yes, please explain: _____

When was your child introduced to solid foods? _____

Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
1.		
2.		
3.		

Please list your child's hospitalization and surgical history:

	Hospitalization / Surgery	Year
1.		
2.		
3.		

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in their lifetime:

	Injury	Year
1.		
2.		
3.		

Has the child ever had x-rays or bloodwork done for any of the things listed above? ☐Yes ☐No

Have you chosen to vaccinate your child?
☐Yes ☐No ☐Yes, on a delayed or selective schedule
If yes, please list any vaccine reactions: _____

_____

Has your child ever received any antibiotics? ☐Yes ☐No
If yes, how many times and list the reason: _____

_____

Do you administer medications like Tylenol or Motrin when your child has a fever? ☐Yes ☐No

How many hours per day does your child typically spend watching a TV, computer, tablet, or phone? _____

How would you describe your child's diet?
☐Mostly whole, organic foods ☐Average ☐Mostly processed foods

Behavioral, Social, and Milestones History

Did / does your child have any difficulty with bonding or social development? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have behavioral or emotional issues? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have any gross motor milestone delays? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have any speech or communication delays? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have any sensory processing challenges? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have any visual or auditory processing challenges? ☐Yes ☐No
If yes, please explain: _____

Did / does your child have any handwriting or fine motor challenges? ☐Yes ☐No
If yes, please explain: _____

Year 1-5 Gross Motor Checklist

0-3 Months Old
- ☐ Raises head and chest when on stomach
- ☐ Stretches and kicks on back
- ☐ Opens and shuts hands
- ☐ Brings hands to mouth
- ☐ Bears weight through feet when held in standing
- ☐ Rotates head from cheek to cheek on tummy
- ☐ Pushes through forearms on tummy
- ☐ Fair head control when held (8+ weeks)

3-6 Months Old
- ☐ Brings feet and hands to mouth to play
- ☐ Supported sitting and prop sitting with hands
- ☐ Good head control and able to hold in midline
- ☐ Holds trunk off legs in sitting (5+ month)
- ☐ Rolls tummy to back
- ☐ Straightens and bears weight on palms during tummy time.
- ☐ Tracks toys while on back
- ☐ Reaches with either hand or can hold toy
- ☐ Transfers object from hand to hand
- ☐ Supports whole weight on legs
- ☐ Begins to pivot to left and right while on belly

6-9 Months Old
- ☐ Rolls back to tummy and tummy to back (no arching)
- ☐ Independent sitting with straight back
- ☐ Able to hold and play with a toy while sitting
- ☐ Able to break fall with open hand
- ☐ Plays in a side seated position
- ☐ Gets from sitting to crawling position
- ☐ Pushes up to hands and knees
- ☐ Army crawls and pivots on belly
- ☐ Pulls up with hands on table
- ☐ Plays on knees
- ☐ Transitions from sitting to tummy
- ☐ Supports weight and bounces in standing (7+ months)

10-12 Months Old
- ☐ Pulls to stand on toy or furniture
- ☐ Can stay standing while holding onto something
- ☐ Transitions from sitting to tummy
- ☐ Transitions from tummy to sitting
- ☐ Transitions from back to sitting
- ☐ 4-point crawls
- ☐ Independent standing for 3-5 seconds
- ☐ Crawls over parents' legs
- ☐ Squats to retrieve toy with support
- ☐ Cruises along furniture and/or walls
- ☐ Pulls to stand, leading with one leg at a time
- ☐ Transitions from bear crawl to stand

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18 Months Old
- ☐ Walks independently
- ☐ Pulls and pushes toys
- ☐ Carries small toys
- ☐ Begins to run (stiff legs and eyes focused on the ground)

24 Months Old
- ☐ Squats to pick up a toy and return to standing without falling
- ☐ Walks up steps with help
- ☐ Takes steps backwards
- ☐ Stands on their tip toes
- ☐ Tosses or rolls a large ball
- ☐ Kicks a ball
- ☐ Climbs on and off furniture without help

3 Years Old
- ☐ Opens doors
- ☐ Throws a ball overhead
- ☐ Attempts to catch a large ball
- ☐ Walks on tip toes
- ☐ Walks in a straight line
- ☐ Kicks a ball forward
- ☐ Jumps with two feet
- ☐ Pedals a tricycle

4 Years Old
- ☐ Hops on one foot
- ☐ Stands on one foot for 5 seconds
- ☐ Catches a bounced ball consistently
- ☐ Moves forward and backward efficiently without loss of balance
- ☐ Walks downstairs with one handrail, alternating
- ☐ Swings independently

5 Years Old
- ☐ Stands on one foot for 10 seconds
- ☐ Swings and climbs on playground equipment efficiently
- ☐ Walks up and down stairs alternating feet without support
- ☐ Beginning to skip
- ☐ Runs while changing directions efficiently

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS IS $60.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF LANDMARK CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

PRINT YOUR NAME HERE **DATE**

_____ _____

SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT**

AT THE TIME X-RAYS ARE TAKEN AT LANDMARK CHIROPRACTIC.

_____ _____

SIGNATURE **DATE**

Practice Member Information (Must be completed before services can be rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY NUMBER: _____ MARITIAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $40 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Andrew Oestreich DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment

Signed_____ **Date**_____

Terms of Acceptance

To provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day Doctor of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**