Newborn – 4 Years old

**CLIENT INFORMATION**:

Date: ____________________ Whom may we thank for referring you: ________________________________________ (Office use Client Number): ______________

Client's Last Name: ___________________________________________________ First: _________________________________________________ M.I.: ___________

Date of Birth: ______ /______ /_______ Age: ________ Name of Parents/Guardians: ____________________________________________________________________

Address: _______________________________________________________________________ City: ____________________________ State: ______ Zip: ____________

Phone numbers: Home: ( ) _____________________________________________ Cell: ( ) _____________________________________________

Phone carrier? (Please circle) *Verizon, T-Mobile, AT&T, Sprint,* or *Other:* ___________________________________________________________________________

E-mail Address: __________________________________________________ How would you prefer to receive an appointment reminder? ☐ E-mail and/or ☐ Text

Other children's names and ages: _____________________________________________________________________________________________

Dr.'s Name: _________________________________ Type of Dr.: __________________________________ Last Appointment Mon/Yr:_________________________

Dr.'s Name: _________________________________ Type of Dr.: __________________________________ Last Appointment Mon/Yr:_________________________

Have you had X-rays taken: ☐ **Yes** ☐ **No**

**INSURANCE**

**We do not take insurance as payment. We can provide you with an insurance form to submit to your insurance company for your reimbursement.**

**FEES**

**FEES: Do you understand and accept these charges?**

**$225** X-rays and Film Analysis (Standard for First Appointment)

**$125** Insight Scan, Exam & Report of Findings (Standard for First Appointment)

**$125** Pediatric First Visit and 1st Adjustment

**$200** Pregnancy First Visit and Adjustment

**$75** Office Visit / Adjustment

**$90** Re-Evaluation

**$100** Office Visit for Nutritional Guidance / Wellness Coaching (Separate from the Adjustment)

***Note that all missed appointments without a phone call will be charged the full amount for visit. ***

***All cancellations must give a 4-hour notice or will be charged $20. ***

**PARENT/GUARDIAN'S SIGNATURE:**

**X**______________________________________________________________________________________________

**Signing gives permission for care** (Parental Signature required for child under age 18) **Date**

Office Client Number: _____________

## HOW CAN WE HELP?

**Review of Condition(s)** (Please be thorough):

Primary reason for visit:_______________

Result of: ❑Car Accident (Ask for an accident form) ❑A worsening long-term problem ❑A new condition

It interferes with: ❑Playing ❑Sleep ❑Walking ❑Sitting ❑Other: _______________

When did you first start noticing current symptoms: _______________

How often does this occur? _______________

❑*Constant* ❑*Comes and goes* (*explain*) _______________

**What have you done to relieve the symptom(s)?**

❑Chiropractic ❑Physical therapy ❑Prescription medications ❑ Massage ❑Surgery ❑Other_______________

Any current medications for which they were prescribed: _______________

**Are there things that make this condition:** Better?_______________Worse?_______________

What else should the doctor know about his/her condition? _______________

*Chiropractic focuses on the integrity of your nervous system, when this system is imbalanced, it can create symptoms and functional diseases. A proper functioning nervous system promotes health and also prevents Dis-Ease.*

Please check or list any **Current** (C), **Past** (P), or **Chronic** (X) problems your child has had on list below:

| **Symptoms:** | | **Previously Diagnosed:** | **Additional Information:** |
|---|---|---|---|
| ___ Acid Reflux | ___ Diarrhea | ___ ADHD | _______________ |
| ___ Hyperactivity | ___ Earaches | ___ Diabetes | _______________ |
| ___ Allergies | ___ Headaches | ___ Heart condition | _______________ |
| ___ Asthma | ___ Insomnia | ___ Hernia | _______________ |
| ___ Bedwetting | ___ Rashes | ___ Hypertension | _______________ |
| ___ Constipation | ___ Frequent Cold/Runny nose | Other: _______ | _______________ |
| ___ Chronic Cough | ___ Seizures | | _______________ |

## PRENATAL HISTORY

Explanation:_______________

Complications during pregnancy: _______________

_______________

Ultrasounds during pregnancy: ❑Yes ❑No Number: _______

Cigarettes/Alcohol Used During Pregnancy: ❑Yes ❑ No

Medications during pregnancy/ delivery: ❑Yes ❑No

List: _______________

## BIRTH & DELIVERY

Location of Birth: ❑Home ❑Birthing Center ❑Hospital ❑Adopted How long was labor: __________

Complications: ❑Yes ❑No List: _______________ Epidural: ❑Yes ❑No Oxytocin / Pitocin: ❑Yes ❑No

Interventions: ❑Manual Force ❑Forceps ❑Caesarian Birth Weight: ______lbs. _______oz. Birth length: ________ in

Genetic disorders or disabilities: ❑Yes ❑No _______________

## FEEDING HISTORY

Breastfed: ❑Yes ❑No How long? _______________ Introduced to solids at ________months.

Formula Fed: ❑Yes ❑No How long? _________ Type: _______________ Cow's milk at ________months.

**Nutrition:** (Please circle)

0 1 2 3 4 5 6 7 8 9 10

**Poor** (processed & fast food) — **Fair** (nutrition inconsistent) — **Excellent** (fruits, vegetables, proteins & healthy fats)

Food/ juice allergies or intolerances: ❑No ❑Yes; List: _______________

Office Client Number: ____________

## DEVELOPMENT HISTORY

Problems sleeping: ❑No ❑Yes; Explain: ____________________

Sleep (hrs. per night): ____________________ Naps (number & lengths): ____________________

At what age was your child able to: Crawl: __________ Sit alone: ________ Stand alone: _________ Walk alone: _________ Say words: _______

Have you noticed any unusual motions during the growing stages? (i.e. consistently looking to open side vs. the other, crawling with one dominant leg and one dragging leg, rolling over in only one direction, etc.)

____________________

## INFANCY & CHILDHOOD

Number of Doses of Antibiotics your child has taken: Past 6 months: ____________________ During life: ____________________

Any prolonged use of medicines or an inhaler? ❑ Yes ❑No Explain: ____________________

Any major trauma such as car accidents? ❑ Yes ❑No Explain: ____________________

Any falls from a height over 3 feet? ❑ Yes ❑No Explain: ____________________

Has the child suffered emotional traumas? ❑ Yes ❑No Explain: ____________________

Please give us any other health information that you feel would be helpful: ____________________

Has the child been under regular chiropractic care? ❑ Yes ❑No

## IMMUNIZATION HISTORY

**Immunizations:** ❑None ❑Reduced Schedule ❑Normal Schedule

Are you aware that there is Mercury, Aluminum, and other chemicals in vaccinations? ❑Yes ❑No

Adverse Reactions to any vaccine? ❑No ❑Yes; List:____________________

## ACKNOWLEDGMENTS

To set clear expectations and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_________ I understand that the chiropractic care offered in this office is based on the best available evidence and is designed to reduce or correct the vertebral subluxation complex. I realize chiropractic is separate from medicine and does not claim to cure any disease. With this knowledge, I permit the chiropractor to deliver care that, in his or her professional judgement, can best help my child in the restoration of their health.

_________ I understand that under the HIPAA, I have certain rights to privacy regarding my protected health information. I acknowledge that I have been given the opportunity to receive a copy of your Notices of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_________ I authorize the performance of x-ray examination of my child if the providing doctor may consider necessary or advisable in the course of treatment. I acknowledge that these x-rays are the sole property of Vita Nova Spinal Care, P.C. and as such will be used exclusively for the purposes unique to care of the providing doctor.

_________ I grant permission for this office to confirm or reschedule an appointment by phone, and to be sent occasional health related cards, letters, or emails.

_________ I acknowledge I am responsible for payments of any insurance covered or non-covered services I receive, and any insurance coverage is an agreement between the carrier and me. I understand that Vita Nova Spinal Care, PC is not a provider for insurance, and is considered an out-of-network provider.

_________ To my best knowledge, the information supplied is complete and truthful without misrepresentation of the existence, origin or severity of my health concerns.

If the client is a minor, print their full name and age: ____________________

**CLIENT'S SIGNATURE:** (*Parental Signature required for child under the age of 18*)

**X** ____________________

**Signing gives permission for care** **Date**