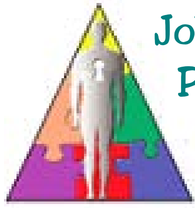

NEW PATIENT PEDIATRIC INFORMATION

Welcome! Please allow our staff to photocopy your Driver's License.

PLEASE PRINT CLEARLY.

Full Name: ____ **Gender**: ☐M ☐F **Age**:____ **Birth Date**: ________________

Address: ____ **City**: ___________________ **State**: ______ **Zip**: ___________

Social Security#: ______-_____-______ **E-mail** ____ **Home Phone**: (_____) _______________

Name of Parents or Guardians: ____

Home Phone: (____) _____________________ **Cell Phone**: (____) ____________________ **Work Phone**: (____) _____________________

In case of an Emergency Contact: ____ **Relationship**: ___________________

Home Phone: (____) _____________________ **Cell Phone**: (____) ____________________ **Work Phone**: (____) _____________________

☐ **Drivers license copied by Office Staff**

Who may we thank for referring you? ____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Johnson Performance & Wellness Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Johnson Performance & Wellness Center to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: ____ Date: ________________

Parent's or Guardian's Signature: ____ Date: ________________

Purpose for contacting us? ____

Other Doctors seen for this condition: □ No □ Yes If yes, Doctors' names and Prior Treatments: ___________________

____

Other Health Problems? ____

Check any of the following conditions your child has suffered from during the past six months:

□ Ear Infections □ Scoliosis □ Seizures □ Chronic Colds □ Headaches

□ Asthma / Allergies □ Digestive Problems □ ADHD □ Recurring Fevers □ Growing / Back Pains

□ Colic □ Bed Wetting □ Car Accident □ Temper Tantrums □ Other:_________________

Family History: ____

Previous Chiropractic care: □ No □ Yes Chiropractor name: ______________________________________

Date of last visit: ________/________/________ Reason: ______________________________________

Name of Pediatrician: ____

Date of last visit: ________/________/________ Reason: ______________________________________

Are you satisfied with the care your child has received there? □ No □ Yes

Number of doses of **Antibiotics** your child has taken:

During the past Six Months: __________ Total during his/her lifetime: __________

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months: __________ Total during his/her lifetime: __________ List: __________________

Vaccination History: ____

Prenatal History:

Name of Obstetrician / Midwife: ____

Complications during pregnancy? □ No □ Yes List: ____

Ultrasounds during pregnancy? □ No □ Yes Number: _____________

Medications during pregnancy / delivery? □ No □ Yes List: _________________________________

Cigarette / Alcohol use during pregnancy? □ No □ Yes

Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section: Emergency or Planned?

Complications during delivery? □ No □ Yes List: ____

Genetic Disorders or Disabilities? □ No □ Yes List: ____

Birth Weight: ________________ Birth Length: ___________________ APGAR Scores: ___________ , _____________

Feeding History:

Breast Fed: □ No □ Yes How long: _____________

Formula Fed: □ No □ Yes How long: _____________ Type: _________________________________

Introduced to solids at: ___________ months, Cow's Milk at __________ months

Food / Juice Allergies or Intolerance: □ No □ Yes List: _____________________________________

____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound: _________________ Cross Crawl: __________________

Respond to Visual Stimuli: _________________ Stand Alone: __________________

Hold Head Up: ___________________ Walk Alone: __________________

Sit Up: ___________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? □ No □ Yes

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? □ No □ Yes List: ____

____

Has your child ever been involved in a car accident? □ No □ Yes List: ____________________________________

Has your child been seen on an emergency basis? □ No □ Yes List: _______________________________________

Other traumas not described above? □ No □ Yes List: ____

Prior surgery? □ No □ Yes List: ____

Menarche? □ No □ Yes Age: ____________

Childhood Diseases:

Chicken Pox: □ No □ Yes, Age: ____________ Mumps: □ No □ Yes, Age: ____________

Rubella: □ No □ Yes, Age: ____________ Rubeola: □ No □ Yes, Age: ____________

Whooping Cough: □ No □ Yes, Age: ____________ Other: □ No □ Yes, Age: ____________

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Authorization For Treatment

Chiropractic has only one goal, to facilitate the correction of vertebral subluxation complexes.
It is important that each patient understand both the objective and the method that will be used to attain it.
This will prevent any confusion or disappointment.

When a patient seeks chiropractic health care and we accept a patient for such care,
it is essential for both parties to be working toward the same objective.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment or loss of the normal ranges of motion of one or more of the 24 vertebrae in the spinal column. These vertebral subluxations interfere with nerve impulse transmission, resulting in a lessening of the body's ability to express its maximum health potential.

Adjustment: A chiropractic adjustment is the specific application of force used to facilitate the body's correction of vertebral subluxations.

Johnson Family Chiropractic does not offer to diagnose or treat any disease or condition other than vertebral subluxations. Our only practice objective is to eliminate interference to the expression of the body's intelligence. Our only method is specific adjusting to correct vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area.

I, ______________________________ for (minor's name)_____________________________ have read and fully understand the above statements. I do hereby authorize Dr. Drew A. Johnson and/or his staff to perform upon me diagnostic and/or therapeutic procedures which are considered necessary or advisable in the *course of my health care.*

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

Patient/Guardian Signature: ____________________ *Date:*______/______/________

Witness: ______________________________________

CONSENT TO X-RAY

I hereby authorize Johnson Performance & Wellness Center and whomever Dr. Johnson may designate as his assistant(s) to take x-rays of said minor for diagnostic purposes. I hereby release Johnson Performance & Wellness Center from any liability.

Signature ____ Date _____________________________