PEDIATRIC PATIENT HISTORY

Child's Name:_____ **SS#:**_____
Last **First** **MI**

DOB: _____ **Grade In School:** _____ **Sex:**_____ **Home Phone: (____)**_____

Address:_____ **City/Town:**_____ **State:**_____ **Zip:** _____

Mother's Name:_____ **Cell/Work Phone:** _____/_____
Last **First**

Father's Name:_____ **Cell/Work Phone:** _____/_____
Last **First**

Referred By:_____ **Purpose of this appointment:** _____

_____

_____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- ❑ Hospital birth
- ❑ Birthing home
- ❑ Long and/or difficult labor
- ❑ Placenta previa
- ❑ Forceps or suction cup used
- ❑ Fetal distress
- ❑ Elective c-section
- ❑ The child was a "blue baby"
- ❑ Home birth
- ❑ The labor was induced
- ❑ The delivery was rapid
- ❑ Breech birth
- ❑ Cord around the neck
- ❑ Emergency c-section
- ❑ The child was premature (2+ weeks)

Comments:_____

_____

_____

PEDIATRIC PATIENT HISTORY

Newborn History
Did the child experience any of the following as a newborn:

- ❑ Required resuscitation/oxygen
- ❑ Prolonged jaundice
- ❑ Poor sleeper
- ❑ Immunizations in hospital
  If yes, specify vaccine:
- ❑ Distorted skull
- ❑ Difficulty latching/sucking
- ❑ Formula fed
- ❑ Breast fed
- ❑ Bottle fed
- ❑ Colic

Weight at birth:_____ Length at birth:_____

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Adverse reaction to any vaccinations (even if mild)
  If yes, please explain:
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems

Developmental History
Does or did your child have any of the following:

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination
- ❑ Did not crawl on all fours
- ❑ Appears clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____
_____
_____

PEDIATRIC PATIENT HISTORY

Neurological/Other
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency
_____
_____

List any special dietary needs that your child has:
_____
_____
_____

List any supplements that your child takes:
_____
_____
_____

List any treatment that your child is currently undergoing with any health professional:
_____
_____

List any special services that your child is currently receiving at school or privately:
_____
_____
_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:
_____
_____

Comments:_____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _____, D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

_____ _____
Signature and relation of person completing this form **Date**

_____ _____
Signature of witness **Date**

SENSORY AND ACADEMIC PROFILE (SAP)
ADOLESCENT TO ADULT (AGES 12+)

Patient Name:_____ Date:_____ Age:_____ Grade:_____

Person Completing this form:_____

Does your child or do you display any of the following behaviors:

F= Frequently **S= Sometimes** **N= Never**

TACTILE				**COMMENTS**
1. Dislike being touched by other people:	F	S	N	_____
2. Like being massaged:	F	S	N	_____
3. Dislike showers or being splashed:	F	S	N	_____
4. Seems to be more sensitive to pain than others:	F	S	N	_____
5. Avoids hands in messy things:	F	S	N	_____
6. Seems excessively ticklish:	F	S	N	_____
7. Bothered by tight or restrictive clothing: (turtlenecks, undergarments, pantyhose)	F	S	N	_____

SMELL				**COMMENTS**
1. Has many allergies:	F	S	N	_____
2. Reacts strongly to smells: (e.g. perfume, cleaning products,)	F	S	N	_____
3. Dislikes furniture, cloths, etc. with smells:	F	S	N	_____
4. Prefers foods with strong taste:	F	S	N	_____

AUDITORY				**COMMENTS**
1. Becomes easily distracted with noises:	F	S	N	_____
2. Has trouble listening or concentrating when background noise is present:	F	S	N	_____
3. Unable to follow 2-3 verbal directions when given at once:	F	S	N	_____
4. Seems to have trouble understanding what is being said:	F	S	N	_____
5. Oversensitive to sounds/noise:	F	S	N	_____

SENSORY AND ACADEMIC PROFILE (SAP)
ADOLESCENT TO ADULT (AGES 12+)

F= Frequently **S= Sometimes** **N= Never**

VISUAL				**COMMENTS**
1. Difficulty with interpreting drawings or comics:	F	S	N	_____
2. Loses place when reading:	F	S	N	_____
3. Becomes easily distracted with visual stimulation:	F	S	N	_____
4. Bothered by bright lights: (e.g. blink a lot, rub eyes, fatigue)	F	S	N	_____
5. Trouble following traffic signs while driving:	F	S	N	_____
6. Trouble with following a moving object:	F	S	N	_____
7. Difficulty putting puzzles together:	F	S	N	_____

VESTIBULAR				**COMMENTS**
1. Seeks fast moving activities/sports:	F	S	N	_____
2. Gets motion sickness:	F	S	N	_____
3. Avoids fast moving amusement park rides:	F	S	N	_____
4. Fearful of heights:	F	S	N	_____
5. Has/had difficulty learning to ride bike:	F	S	N	_____
6. Difficulties with balance:	F	S	N	_____
7. Difficulty merging onto freeway (adults):	F	S	N	_____
8. Difficulty walking on uneven surfaces:	F	S	N	_____

PROPRIOCEPTION				**COMMENTS**
1. Poor/weak grasp; frequently drops things:	F	S	N	_____
2. Poor posture; slumps in chair:	F	S	N	_____
3. Clumsy or bumps into things a lot:	F	S	N	_____
4. Difficult judging amount of force needed to perform a task:	F	S	N	_____
5. Difficulty finding objects in purse, pocket, or backpack without looking:	F	S	N	_____
6. Difficulty licking ice-cream cone:	F	S	N	_____
7. Tires easily with physical activity or writing:	F	S	N	_____
8. Difficulty with sitting still and not moving frequently in chair:	F	S	N	_____
9. Tends to be a slow eater:	F	S	N	_____
10. Has difficulty learning exercises or dances that have several steps:	F	S	N	_____

SENSORY AND ACADEMIC PROFILE (SAP)
ADOLESCENT TO ADULT (AGES 12+)

Patient Name:_____ Date:_____ Age:_____ Grade:_____

Does your child or do you display any of the following behaviors:

F= Frequently **S= Sometimes** **N= Never**

SOCIAL & EMOTIONAL				**COMMENTS**
1. Becomes easily frustrated:	F	S	N	_____
2. Strong desire for sameness or routine:	F	S	N	_____
3. Lack self-confidence:	F	S	N	_____
4. Prefers to be alone:	F	S	N	_____
5. Experiences anxiety or panic attacks:	F	S	N	_____

Do you experience difficulties with any of the following:

❑ Reading
❑ Math
❑ Spelling
❑ Handwriting
❑ Organization skills
❑ Following Directions
❑ Sleep
❑ Sitting still
❑ Sports
❑ Remembering Information
❑ Paying Attention
❑ Finishing Tasks
❑ PE or Exercise

How concerned are you about the above checked problems:

❑ Not Concerned ❑ Moderately Concerned ❑ Very Concerned

How would you say the above checked problems interfere with your daily life:

❑ Not at all ❑ Slightly Interferes ❑ Moderately Interferes ❑ Greatly Interferes

Comments/Concerns: _____
_____
_____
_____

Get Moving Chiropractic 30772 Southview Dr., Suite 140 Evergreen, CO 80439 (303) 670- 7777

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Get Moving Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: Services Received

I hereby authorize payment to be made directly to Get Moving Chiropractic, for all benefits which may be payable under a health care plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Get Moving Chiropractic for any and all services I receive at this office.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

JDD,DC 5/2011

Notice of Privacy Practices Acknowledgement
Get Moving Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice 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.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

OUR OFFICE POLICIES

Welcome to GET MOVING CHIROPRACTIC!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*****,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Get Moving Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1) diversified adjustments OR 2) a variety of techniques to accomplish this goal, including but not limited to therapeutic exercises. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Get Moving Chiropractic Dr. Katy R. Mooberry DC, CACCP

30772 Southview Dr. #140 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

New Patient Consent Form

*Please read the following carefully and initial each statement on the line provided.

____ Financial Policy and Agreement: Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a $30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you have a zero balance. If you have insurance that pays for chiropractic care, we will be glad to bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements please talk with us. I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collections, attorney's fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account. **Insurance is billed by code; payment varies by plan.**

____ Patient Release and Agreement: I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Get Moving Chiropractic all medical benefits otherwise payable for medical services. I authorize the use of this signature on all my insurance submissions and to obtain medical records.

_____ Consent and Agreement: Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms, broken bones and strokes. The more serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can assist you further.

THERE IS A 24 HOUR CANCELLATION POLICY OR YOUR ACCOUNT WILL BE CHARGED $25.00.

I have read all three of the above agreements and I accept these terms and conditions.

_____ _____

Patient signature or Guardian if patient is under 18 years of age Date