

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:

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

Labor and Delivery History

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

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

Comments: _____

PEDIATRIC PATIENT HISTORY

Newborn History

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

- | | |
|--|--|
| <input type="checkbox"/> Required resuscitation/oxygen | <input type="checkbox"/> Distorted skull |
| <input type="checkbox"/> Prolonged jaundice | <input type="checkbox"/> Difficulty latching/sucking |
| <input type="checkbox"/> Poor sleeper | <input type="checkbox"/> Formula fed |
| <input type="checkbox"/> Immunizations in hospital | <input type="checkbox"/> Breast fed |
| If yes, specify vaccine: | <input type="checkbox"/> Bottle fed |
| | <input type="checkbox"/> 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:

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

If yes, please explain:

Developmental History

Does or did your child have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours) | <input type="checkbox"/> Did not crawl on all fours |
| <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Appears clumsy |
| <input type="checkbox"/> Difficulty learning to read | <input type="checkbox"/> Difficulty with writing |
| <input type="checkbox"/> Difficulty using utensils | <input type="checkbox"/> Difficulty buttoning clothing |
| <input type="checkbox"/> Difficulty tying shoes | <input type="checkbox"/> Difficulty or awkward with walking/running |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> 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)
AGES 3-4

Child's Name: _____ Date: _____ Age: _____ Grade: _____

Person completing this form: _____

Has or does your child display any of the following behaviors:

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

TACTILE	F	S	N	COMMENTS
1. Avoids touch or contact:	F	S	N	_____
2. Dislikes messy play (e.g. finger painting, dough)	F	S	N	_____
3. Dislikes tags in clothing:	F	S	N	_____
4. Is constantly touching things:	F	S	N	_____
5. Frequently hits or pushes other children:	F	S	N	_____
6. Dislikes undergarments or prefers to wear them inside out:	F	S	N	_____
7. Constantly pulls or rubs clothing:	F	S	N	_____
8. Seems to over-react to slight bumps, scrapes, or bruises:	F	S	N	_____
9. Dislikes rigid clothing (e.g. jeans) or tight clothing (waistbands, turtlenecks):	F	S	N	_____
10. Resists wearing short sleeves or short pants:	F	S	N	_____
11. Does not like to be cuddled or hugged:	F	S	N	_____
12. Continues to put objects in mouth:	F	S	N	_____

SMELL	F	S	N	COMMENTS
1. Needs to smell items or people:	F	S	N	_____
2. Negative behavioral changes or gets sick with cleaning days (same day or next day):	F	S	N	_____
3. Does not like new cloths or toys with smells:	F	S	N	_____
4. Dislikes strong smells:	F	S	N	_____
5. Craves strong smells:	F	S	N	_____
6. Eats non-edible items:	F	S	N	_____
7. Smears his or her feces:	F	S	N	_____

SENSORY AND ACADEMIC PROFILE (SAP)
AGES 3-4

F= Frequently

S= Sometimes

N= Never

AUDITORY	F	S	N	COMMENTS
1. History of repeated ear infections:	F	S	N	_____
2. Is distracted by noises; seems to hear noises that go unnoticed by others:	F	S	N	_____
3. Covers ears frequently:	F	S	N	_____
4. Speaks in a loud voice:	F	S	N	_____
5. Hums or sings to screen out noise:	F	S	N	_____
6. Has trouble following 1-2 step commands:	F	S	N	_____
7. Delayed speech development:	F	S	N	_____
8. Doesn't respond consistently to verbal clues:	F	S	N	_____
9. Is hard to understand when he/she speaks:	F	S	N	_____

VISUAL	F	S	N	COMMENTS
1. Often loses place when reading:	F	S	N	_____
2. Has difficulty matching shoes and socks:	F	S	N	_____
3. Prefers solid patterns over distracted patterns:	F	S	N	_____
4. Often squints:	F	S	N	_____
5. Is unable to read/scan across page without losing place:	F	S	N	_____
6. Has strong visual memory:	F	S	N	_____
7. Pays attention to details but has difficulty seeing the whole:	F	S	N	_____
8. Has trouble staying between the lines when coloring or writing:	F	S	N	_____
9. Has difficulty putting puzzles together:	F	S	N	_____
10. Prefers darker setting; doesn't like bright light:	F	S	N	_____
11. Hesitates going up/down stairs:	F	S	N	_____

SENSORY AND ACADEMIC PROFILE (SAP)

AGES 3-4

Child's Name: _____ Date: _____ Age: _____ Grade: _____

Has or does your child display any of the following behaviors:

F= Frequently

S= Sometimes

N= Never

VESTIBULAR				COMMENTS
1. Unable to sit still; in constant motion:	F	S	N	_____
2. Does not like going up/down stairs:	F	S	N	_____
3. Often rocks or bangs head:	F	S	N	_____
4. Doesn't like being upside down:	F	S	N	_____
5. Avoids playground activities:	F	S	N	_____
6. Loves swinging or spinning:	F	S	N	_____
7. Has difficulty learning to catch a ball:	F	S	N	_____
8. Avoids play activities that involve movement:	F	S	N	_____
9. Gets motion sickness:	F	S	N	_____
10. Has poor balance:	F	S	N	_____

PROPRIOCEPTION				COMMENTS
1. Frequently drops objects:	F	S	N	_____
2. Exerts too little or too much pressure with objects (e.g. frequently breaks crayons, pencils or squeezes toothpaste to light or hard):	F	S	N	_____
3. Likes to be cuddled/hugged/squeezed:	F	S	N	_____
4. Does not like to sleep with light off:	F	S	N	_____
5. Does not like doing tasks with eyes closed: (pulling shirt over head, closing eyes to wash hair):	F	S	N	_____
6. Seems to tire easily; especially with writing, drawing, or eating:	F	S	N	_____
7. Does not like foods that require a lot of of chewing:	F	S	N	_____
8. Difficulty with dressing (e.g. putting leg in pant hole, buttoning)	F	S	N	_____
9. Appears stiff, awkward, or clumsy:	F	S	N	_____
10. Walks on toes:	F	S	N	_____
11. Writes with tongue hanging out:	F	S	N	_____

SENSORY AND ACADEMIC PROFILE (SAP)
AGES 3-4

F= Frequently

S= Sometimes

N= Never

LANGUAGE	F	S	N	COMMENTS
1. States full name, age, and address: (at least 2 out of 3)	F	S	N	_____
2. Intelligible 3-5 word phrases:	F	S	N	_____
3. Answers questions such as, "What do you want to do for fun?" with plurals, personal pronouns, and verbs:	F	S	N	_____

EMOTIONAL & DEVELOPMENTAL	F	S	N	COMMENTS
1. Has difficulty with a change in routines:	F	S	N	_____
2. Does not like to play in groups- often plays on the outskirts:	F	S	N	_____
3. Is easily frustrated:	F	S	N	_____
4. Has frequent outbursts or tantrums:	F	S	N	_____
5. Tends to be impulsive or accident prone:	F	S	N	_____
6. Avoids eye contact:	F	S	N	_____
7. Has difficulty expressing needs:	F	S	N	_____
8. Goes up and down stairs with alternating feet:	F	S	N	_____
9. Responds to commands to place an object "in", "on", or "around" something: (e.g. "Put the ball in the box")	F	S	N	_____
10. Buttons own clothing:	F	S	N	_____
11. Feeds self at mealtime:	F	S	N	_____
12. Engages in make-believe & pretend play:	F	S	N	_____
13. Is able to copy a circle:	F	S	N	_____

How concerned are you about the above checked problems:

Not Concerned

Moderately Concerned

Very Concerned

How would you say the above checked problems/difficulties interfere with your child's daily life:

Not at all

Slightly Interferes

Moderately Interferes

Greatly Interferes


Comments/Concerns: _____

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

**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