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**Infant Information (0-12 months)**

Date \_\_\_\_\_ Child's legal name \_\_\_\_\_

Parent(s) Names \_\_\_\_\_

Siblings' names and ages \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ Postal Code \_\_\_\_\_

Parent's e-mail address \_\_\_\_\_

Date of Birth \_\_\_\_m/\_\_\_\_d/\_\_\_\_y/  Male  Female  \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell number of: \_\_\_\_\_

Home Phone \_\_\_\_\_ Whom may we thank for referring your child to this office? \_\_\_\_\_

Reason for your child seeking services at our office: \_\_\_\_\_

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

Date of last visit \_\_\_\_\_ Purpose of visit \_\_\_\_\_

**Health Concerns**

Please list your child's health concerns according to their severity:

Concern	When did it start? For how long?	If you had the condition before, when?
1.		
2.		
3.		

**Pregnancy and Birth History**

Gestational Duration: \_\_\_\_\_ weeks

**PHYSICAL STRESS** Trauma/Falls during pregnancy \_\_\_\_\_

Any ultrasounds or other radiation? \_\_ Yes \_\_ No How many and for what reasons? \_\_\_\_\_

Invasive Procedures (Eg. Amniocentesis, CVS) ?  No  Yes If yes, what procedure? \_\_\_\_\_

**CHEMICAL STRESS** During the pregnancy did the mother:

Smoke?  Yes  No How much? \_\_\_\_\_ Drink Alcohol?  Yes  No How much? \_\_\_\_\_

Prescription Medications?  Yes  No How much? \_\_\_\_\_ Recreational Drugs?  Yes  No How much? \_\_\_\_\_

Fall ill during pregnancy?  Yes  No please explain \_\_\_\_\_

Were any supplements taken during the pregnancy?  Yes  No Please list: \_\_\_\_\_

**EMOTIONAL STRESS**

Please rate the mother's stress levels during pregnancy 1-10 (1= low, 10=high): \_\_\_\_\_

**LABOR**

Was labor induced?  Yes  No Duration of labor? \_\_\_\_\_ Duration of active (pushing stage) labor? \_\_\_\_\_

Did mother receive medications?  Yes  No If yes, which: \_\_\_\_\_

**BIRTH**

Type of birth?  Vaginal: Cephalic (head first)  Breech (feet first)  C-Section

Location of birth?  Home  Hospital  Birthing center Birth Assistants?  Midwife  Doula  Obstetrician

Was there any assistance needed during birth?  Forceps  Cesarean  Vacuum Extraction  Induction  
 Assisted Traction/Head Turning

Was delivery considered normal?  Yes  No Were there complications during birth?  Yes  No

Please explain: \_\_\_\_\_

Was there any evidence of birth trauma to the infant? Check all that apply:

Bruising  Odd shaped head  Stuck in birth canal  Fast or excessively long birth

Respiratory depression  Cord around neck

Did your child have any of the following? Check all that apply:

Silver nitrate drops in eyes  Incubation How long? \_\_\_\_\_

Separation from you  Hepatitis shot  Vitamin K shot

Did your child spend any time in intensive care? Yes No If yes, how long? \_\_\_\_\_

APGAR score at birth? \_\_\_\_\_ APGAR score at 5 minutes? \_\_\_\_\_

Birth Weight? \_\_\_\_\_ Birth Length? \_\_\_\_\_

**Childhood History**

**PHYSICAL STRESS**

Does your child have a preferred sleeping position?  Yes  No \_\_\_\_\_

Did your child prefer one-sided breast-feeding position?  Yes  No \_\_\_\_\_

Did your baby spit up after feeding?  Yes  No \_\_\_\_\_

Has your child had any falls or injuries?  Yes  No \_\_\_\_\_

Does your child ever bang his/her head repeatedly?  Yes  No \_\_\_\_\_

Any traumas resulting in bruises, fractures, stitches?  Yes  No \_\_\_\_\_

Any hospitalizations or surgeries?  Yes  No \_\_\_\_\_

Please list any surgeries your child has had:

1. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Has your child ever had x-rays taken?  Yes  No When? \_\_\_\_\_ Where? \_\_\_\_\_

**CHEMICAL STRESS**

Was/is child breast-fed?  Yes  No For how long? \_\_\_\_\_

At what age was: Formula introduced? \_\_\_\_\_ Brand? \_\_\_\_\_

Cow's milk introduced? \_\_\_\_\_ Solid food? \_\_\_\_\_

Does your child have food allergies?  Yes  No \_\_\_\_\_

What is your child's favorite food? \_\_\_\_\_ What does your child regularly drink? \_\_\_\_\_

Does your child have a bowel movement every day?  Yes  No \_\_\_\_\_

Does your child have regular or occasional skin rashes?  Yes  No \_\_\_\_\_

Has your child had any reactions to vaccinations or medications?  Yes  No \_\_\_\_\_

Has your child had any antibiotics?  Yes  No How many courses in the child's lifetime? \_\_\_\_\_

Reason and length of last course of antibiotics? \_\_\_\_\_

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ For what? \_\_\_\_\_

Are there pets in the home?  Yes  No \_\_\_\_\_ Are there any smokers at home?  Yes  No

**EMOTIONAL STRESS**

Did mother have any difficulties with breast-feeding?  Yes  No \_\_\_\_\_

Did mother and baby have difficulty bonding?  Yes  No \_\_\_\_\_

Did mother experience any post-partum depression?  Yes  No \_\_\_\_\_

Do you consider their sleeping pattern normal?  Yes  No \_\_\_\_\_

Quality of Sleep?  Good  Fair  Poor      Number of hours \_\_\_\_\_

Does your child attend day care?       Yes       No      From what age? \_\_\_\_\_

Has your child ever been abused, a victim of a crime or experienced a significant trauma?  Yes  No If yes, please describe: \_\_\_\_\_

**GROWTH AND DEVELOPMENT**

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Was your child alert & responsive within 12 hours of delivery?  Yes  No

If no, please explain: \_\_\_\_\_

**FAMILY HISTORY**

Describe any medical family history on **mother's side**: (EG cancer, diabetes etc) \_\_\_\_\_

On **father's side**: \_\_\_\_\_

Are there any health concerns with sibling(s)?  Yes  No If yes, please describe: \_\_\_\_\_

## ***Informed Consent to Chiropractic Care***

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

**Adjustment:** An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

**Health:** A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)

Patient's Name: \_\_\_\_\_ Doctor's Initials \_\_\_\_\_ Page 5

**Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.**

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I, (Parent or Legal Guardian's name): \_\_\_\_\_ have read and fully understand the above statements.

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis for my child. I intend this consent form to cover the entire course of my child's care in this office with Dr. Jennifer Pitcairn or other attending chiropractor.

(Parent or Legal Guardian's signature) \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to assess and adjust a minor:**

I, (Parent or Legal Guardian's name): \_\_\_\_\_, being the

parent or legal guardian of (CHILD's NAME) \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

**Complete Health Chiropractic Center, LLC  
Authorization for Treatment of Minor Child**

Patient name (print): \_\_\_\_\_

**I authorize** Complete Health Chiropractic Center and/or Dr. Jennifer Pitcairn to treat my minor child without parental presence in the office.

**OR**

**I DO NOT authorize** Complete Health Chiropractic Center and/or Dr. Jennifer Pitcairn to treat my minor child without parental presence in the office.

Parent or Legal Guardian's name (print): \_\_\_\_\_

Parent or Legal Guardian's signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Complete Health Chiropractic Center, LLC

## Notice of Privacy Practices Acknowledgement

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.

**(Print) Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient or Legal Guardian's Signature** \_\_\_\_\_

### Authorization to discuss Personal Health Information (PHI)

I authorize Complete Health Chiropractic Center and/or Dr. Jennifer Pitcairn to discuss details of my care and personal health information with the following person/people:

Name (print): \_\_\_\_\_ Relationship to me: \_\_\_\_\_

Name (print): \_\_\_\_\_ Relationship to me: \_\_\_\_\_

### Please check one: This authorization is effective through:

\_\_\_ Date: \_\_\_\_\_ OR \_\_\_ NO expiration unless revoked or terminated by the patient or the patient's personal representative.

\*\*\*\*\*

### Records:

I authorize Complete Health Chiropractic Center to share my records with my Primary Care Physician.

\_\_\_ Y \_\_\_ N

Primary Care Physician's name: \_\_\_\_\_

Clinic/Office \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\*\*\*\*\*

### 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: \_\_\_\_\_





Complete Health  
Chiropractic Center, LLC

Complete Health Chiropractic Center, LLC

Jennifer Pitcairn, D.C.  
365 Warner Milne Rd., Suite 105  
Oregon City, OR 97045

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_@\_\_\_\_\_

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** \_\_\_/\_\_\_/\_\_\_ **Gender (Circle one):** Male / Female **Preferred Language:** \_\_\_\_\_

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

**Do you have any medication allergies?**

Medication Name	Reaction	Onset Date	Additional Comments

**I choose to decline receipt of my clinical summary after every visit** (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For office use only</b>		
Height: _____	Weight: _____	Blood Pressure: _____ / _____