Complete Health
Chiropractic Center, LLC

Tel: (503) 557-9266
Fax: (503) 557-9220
365 Warner Milne Rd., Suite 105,
Oregon City, OR 97045
info@completehealthcc.com
completehealthcc.com

Child Information (1-5 years)

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 heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

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 your 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 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 _____

Any falls or injuries down stairs, bicycle etc? __ Yes __ No _____

Does 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 all surgeries your child has had:
1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).
1. Type_____ When_____ Hospitalized? __ Yes __ No

2. Type_____ When_____ Hospitalized? __ Yes __ No

Have you ever had x-rays taken? __ Yes __ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? __ Yes __ No If yes, hours per week? _____Age child began? _____

Is school backpack used? __ Yes __ No Weight of backpack? _____kg/lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? __ Yes __ No _____

Does your child have trouble reading the board? __ Yes __ No _____

Does your child have difficulty with coordination? __ Yes __ No _____

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? _____

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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 _____

Night terrors, sleep walking, difficulty sleeping __ Yes __ No _____

Do you consider their sleeping pattern normal? __ Yes __ No _____

Quality of Sleep? __ Good __ Fair __ Poor Number of hours _____

Behavior problems? __ Yes __ No _____

Do you feel that your child's social and emotional development is normal for their age? __ Yes __ No

Does your child attend day care? __ Yes __ No From what age? _____

Does your child have emotional distress? __ No __ Yes If yes, please circle from 1(mild) to 10 (severe):
1 2 3 4 5 6 7 8 9 10 Please describe:_____

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)

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

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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:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

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:

_____ NONE

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: _____