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 (6-13 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

Did the mother experience any physical, chemical or emotional stress during pregnancy? __ Yes __ No If yes, please describe: ____

BIRTH

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

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:____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? __ Yes __ No ____________________________________

Any falls or injuries down stairs, bicycle etc? __ 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 ___________________________________

Complete Health Chiropractic Center, LLC 365 Warner Milne Rd., Suite 105 Oregon City, OR 97045

CHEMICAL STRESS

Does your child have food allergies? __ Yes __ No____

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

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 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: _________________

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

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: ______________________