Child (1-12 Yrs) Information

Date _____

Child's Name _____

Parent(s) Names

_____

Siblings' Names and Ages

_____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address

_____

Would you like to receive our "Living Healthy" e-newsletter? ◯ Yes ◯ No

Date of Birth _____m/_____d/_____y/ Gender: ◯ Male ◯ Female

Home Ph _____ Business Ph _____ Mobile Ph _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

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

Name & Address of Obstetrician/ Midwife:

_____

Name & Address of 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) ? ◯ Yes ◯ No

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):_____

LABOUR

Was labour induced? ◯ Yes ◯ No

Duration of labour? _____

Duration of active (pushing stage) labour?_____

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

Was your child subjected to any of the following? Check all that apply:

◯ Silver nitrate drops in eyes ◯ Incubation How long? _____

◯ Vitamin K shot ◯ Separation from you How long? _____

◯ Hepatitis 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 _____

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

3. 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? _____

Food/juice intolerance? ◯ Yes ◯ No_____

Does your child have food allergies? ◯ Yes ◯ No_____

What is your child's favourite food? _____

What does your child regularly drink? _____

The type of diet your child usually follows is classified as: _____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs _____ Fasting _____ Fruit _____

Fish	_____	Diet Food	_____	Organic Foods	_____		
Coffee	_____	Beef	_____	Weight Control Diet	_____	Raw Vegetables	_____
Soft Drink	_____	Poultry	_____	Artificial Sweetener	_____	Whole Grains	_____
Fried Foods	_____	Seafood	_____	Cooked vegetables	_____		
Refined Sugar	_____	Dairy	_____	Canned/Frozen vegetable	_____		

Does your child have a bowel movement every day? ◯ Yes ◯ No _____

Does your child have regular or occasional skin rashes? ◯ Yes ◯ No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Un-consolable crying

◯ Irritability ◯ Arching of body

◯ Bowel disturbances ◯ Feeding disturbances

◯ Drowsiness ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many coursed of antibiotics has your child received in their 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? _____

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?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

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? _____

GROWTH AND DEVELOPMENT

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

If no, please explain: _____

At what age did your child:

Respond to sound?	_____	Sit alone?	_____
Follow an object?	_____	Teethe?	_____
Hold head up?	_____	Crawl?	_____
Vocalize?	_____	Walk?	_____

FAMILY HISTORY

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

_____

On father's side:

_____

Does sibling's have any health concerns? ◯ 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.

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, _____ have read and fully understand the above statements.
(PRINT NAME)

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

_____

(SIGNATURE) (DATE) (WITNESS)

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of

(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms

(CHILD'S NAME)

of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

How we protect your Health Information:

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to Connected Chiropractic (Practice) as follows:

1. Connected Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; b) an e-mail sent to the e-mail address provided by me; c) a text message sent to the cell phone number provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not treat me.

I have read and understand the health information disclosure and protection in the foregoing notice,

_____ _____

PRINTED Name SIGNATURE

_____

DATE

_____ _____

Signature of Legal Guardian (e.g. if a minor) Relationship to minor

NO SHOW/MISSED APPOINTMENT POLICY

We, at Connected Chiropractic and Vitality Massage understand that sometimes you need to cancel or reschedule
your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 4-hour notice).

You can cancel appointments by calling or texting the following number: **970-587-7029.**

Or you can e-mail **deskchiro@gmail.com.**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder text to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel or reschedule your appointment with at least a 4 hours' notice.

2. If less than a 4-hour cancellation is given this will be documented as a No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a ''No-Show'' appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Connected Chiropractic or Vitality Massage will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed the full fee for the missed appointment.

I have read and understand Connected Chiropractic's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Connected Chiropractic appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____

Staff Signature Date

Dr. Brad Cranwell
32 S. Rutherford Avenue
Johnstown, CO 80534
970-587-7029

Patient Care Agreement List

I agree to follow Dr. Brad's recommendation to achieve best results:

___I will begin to dramatically increase my daily water consumption.
(The goal is to drink at least ½ my body weight in ounces of water daily)

___I will begin to decrease my daily caffeine consumption.

___I will adjust all my fixed body positions for the better (work, desk, home, car, etc.)

___I will not consciously go to sleep on my stomach.

___I will be aware of my head posture for the next hour after an adjustment.

___I will use the Cervical or Lumbar therapeutic equipment if recommended.

___I will get a posture-pedic pillow.

___I will inform Dr. Brad of the positive or negative changes in my health. I will also let Dr. Brad know if there are any changes to my goals.

___I am responsible for any appointments cancelled within 4 hours or "no-shows". The office policy states that, if I "no-show" for an appointment and don't call to reschedule it OR if I call to reschedule an appointment with less than four (4) hours' notice, the full amount for the appointment will be charged to my card on file. This applies to all types of appointments with Connected Chiropractic and/or Vitality Massage Studio.

Patient Signature: _____ Date:_____