Infant & Baby Health Questionnaire (0 - 12mo)

Personal Information:

Date: _____

Child's Name: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Gender: M F

Soc. Sec #: _____

Child's Home Phone No. ( ) _____

Mother's Name: _____

Mother's Cell Phone No. ( ) _____

Mother's E-mail: _____

Mother's Employer: _____

Work Phone: ( ) _____ Ext: _____

Father's Name: _____

Father's Cell Phone No. ( ) _____

Father's E-mail: _____

Work Phone: ( ) _____ Ext: _____

Number of Siblings: _____ Ages: _____

Referred By: _____

Interested in appointment reminders? O Email O Text

Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: ( ) _____ O Home O Cell

Office Phone: ( ) _____ Ext: _____

Pediatrician/PCP's Name: _____

Insurance Information:

Do you expect insurance to contribute to your baby's care? O Yes O No

Insured's Name: _____ DOB: _____

Relationship to Child: _____ Effective Date: _____

Insurance Company: _____

ID *or* Contract Number: _____

Group *or* FECA Number: _____

Phone Number: ( ) _____ Ext: _____

Adjuster *or* Contact Name: _____

Claims Address: _____

Lifestyle Information:

How would you rate you baby's ability to physically move without any limitations or restrictions?

O Excellent O Very Good O Good O Average O Poor

How do you rate your diet if nursing or the quality of the formula you are providing for your baby?

O Excellent O Very Good O Good O Average O Poor

How do you rate your awareness and effort to avoid environmental chemicals and toxins for your baby?

O Excellent O Very Good O Good O Average O Poor

How do you rate your baby's psychological and emotional environment? (Excellent = Little Stress, Poor = Very Stressful)

O Excellent O Very Good O Good O Average O Poor

On a scale (1 worst, 10 best) how would you rank your baby's overall health & wellness status thus far?

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

On a scale (1 least, 10 most) how would you rank your priority for your baby's health?

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Subluxation Related Complaints:

The goal of your baby's chiropractic evaluation is to identify neurological stress and abnormal neuro-structural patterns called spinal subluxations. Although chiropractic care is not a treatment for any specific medical condition it is common for spinal subluxations to be directly or indirectly related to many of the following infant related conditions. Please check if your child has any of the following:

- O Asymmetrical Facial Features
- O Poor Eye Control / Movements
- O Head Tilt / Torticollis
- O Head Distortion/ Plagiocephaly
- O Ear Aches / Ear Infections
- O Colic / Excessive Crying / Irritability
- O GERD / Acid Reflux / Frequently Spits-up
- O Constipation / Diarrhea
- O Difficulty Nursing / Latching
- O Back Arching / Tension
- O Dislike of Tummy Time
- O Seizures / Neurological Ticks
- O Failure to Thrive
- O Abnormal Sleep Patterns
- O Skin Problem / Rash / Eczema
- O Intolerances to Formula / Foods in Nursing Mom's Diet

General Health:

Child's Name: _____ Date: _____

Diet History:

Was your baby breast fed? O Exclusively Breastfed O Previously Breastfed O Breastfed and Formula Fed

Formula Details (if Applicable): O Milk O Soy O Organic O Homemade O Special: _____

Supplements your baby takes directly: _____

Supplements mom takes if nursing: _____

Vaccinations History: O Up-to-Date O Partial O Delaying O Conscientious Objector O Concerned/Unknown

O Vaccine Reactions: _____

Pregnancy History:

Please provide us with information as it relates to your pregnancy with this child by checking all that apply:

- O Accident While Pregnant
- O Alcohol Consumption
- O Amniocentesis
- O Abnormal Fetal Position or Breech
- O Chemical Exposure
- O Frequent Ultrasounds: # _____
- O Genetic Testing
- O Gestational Diabetes
- O Group-B Strep Positive
- O Hypertension
- O Bacterial or Viral Infection
- O Yeast/Fungal Infection
- O Morning Sickness / Nausea
- O Placenta Abruptio
- O Placenta Previa
- O Poor Nutrition
- O Pre-Eclampsia
- O Prescription Medication
- O Radiation Exposure
- O Recreational Drug Use
- O Rhogam Injection
- O Swelling or Edema
- O Pre-Natal Vitamins
- O Unknown/Adopted

Birth & Labor History:

Birth Weight: _____ *Place of Birth:* O Hospital O Birthing Center O Home

Birth Height: _____ *Birth Care Providers:* O OB/Gyn O Midwife O Doula

Final APGAR: _____

Please check all that apply in regards to your labor and the birth process for this child:

- O Fetal Monitoring
- O Abnormal or Breech Presentation
- O Cord Around Neck
- O Labor Induced
- O Rupture of Membranes
- O Pitocin Administered
- O Long and/or Difficult Labor
- O Antibiotics Administered
- O Pain Medication
- O Epidural
- O Lack of Fetal Decent
- O Lack of Progression
- O Fetal Distress
- O Meconium
- O Forceps
- O Suction Device
- O Obstetrical Pulling
- O Cesarean Section

Post Natal History:

Choose all that apply for your baby as a newborn:

- O Resuscitation/Oxygen Required
- O Prolonged Cranial Distortion
- O Difficulty Nursing/Latching/Suckling
- O Meconium Aspiration/Stomach Pumped
- O Antibiotic Administered
- O Circumcised
- O Premature
- O Poor Sleeping
- O Jaundice
- O Low APGAR score
- O Failure to Thrive
- O Colic

Family History:

- O Arthritis
- O Cancer
- O Cardiovascular/ Heart Disease
- O Diabetes
- O Hypertension
- O Genetic Disorder
- O Unknown/ Adopted

Child's Name: _____ Date: _____

Infant Health History (ROS):

Constitutional:
- O Fever
- O Abnormal Tone
- O Recent Trauma
- O Irritability
- O High Pitched Crying
- O Poor Sleep
- O Poor Weight Gain
- O Weight Loss

EENT:
- O Excessive Tearing
- O Blocked Tear Duct
- O Conjunctivitis
- O Poor Eye Control
- O Poor Hearing
- O Ear Aches
- O Discharge from Ear
- O Poor Smell
- O Nasal Congestion
- O Difficulty Swallowing
- O Tongue Tied
- O Spots on Tongue
- O Thrush

Respiratory:
- O Difficulty Breathing
- O Shortness of Breath
- O Wheeze
- O Sputum
- O Cough

Genital:
- O Undescended Testes
- O Hydrocele
- O Testicular Torsion
- O Circumcision Concern
- O Gonadal Mass
- O Genital Rash
- O Vaginal Discharge
- O Breast Mass

Integumentary:
- O Jaundice
- O Skin Rash / Eczema
- O Diaper Rash
- O Bruises
- O Scars
- O Skin Masses/Bumps
- O Skin Color Changes

Musculoskeletal:
- O Swelling of Muscles/Joints
- O Limited Range of Motion
- O Fall from a High Surface

Neurological:
- O Seizures
- O Neurological Ticks
- O Convulsions
- O Tremors
- O Uncoordinated Movements

Cardiovascular:
- O Cyanosis (blue/purple color)
- O Cold Hands or Feet
- O Extremity Swelling
- O Abnormal Heart Rhythm

Immunological:
- O Food Intolerance
- O Environmental Intolerance
- O Allergy
- O Lymph Node Enlargement
- O Meningitis
- O Serious Infection

Gastrointestinal:
- O Bloating
- O Constipation
- O Diarrhea
- O Stomach Tenderness
- O Excessive Spitting-up
- O Vomiting
- O Lack of Nursing or Eating
- O Bloody Stools
- O Dark Tarry Stools
- O Rectal Rash

Endocrine:
- O Neck or Thyroid Mass
- O Abnormal Growth Patterns
- O Excessive Sweating

Urinary:
- O Difficult Urination
- O Foul Smelling Urine
- O Sweet Syrup Smelling Urine
- O Blood in Urine
- O Seemingly Painful Urination

Medical History:

*Please list any **Prescription Medications** your child takes:*

_____
_____
_____

*Please list any **Surgical Procedures** your child has had:*

_____
_____
_____

*Has your child ever needed any **Emergency Services**?*

_____
_____
_____

*List any known **Allergies** that your child currently has:*

_____
_____
_____

Minor Consent

Consent for Evaluation and Treatment

of a Minor Child:

I hereby authorize the Doctor to treat my child's conditions as he/she deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary to my child"

Child's Name: _____

Parent/Guardian Name: _____

▶ **Guardian Signature:** _____

Date: _____

SPENCER CHIROPRACTIC & WELLNESS CENTER

Name: _____ Date:

1025 5th Ave SE
Spencer, IA 51301
712-580-3294

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy office and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by the is office.
8. Our office reserves the right to make change to this notice and to make the new notice provisions effected for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purposed of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____

Name of Patient (Please Print) Date

_____ _____

Signature Parent, Guardian, or Legal Representative

SPENCER CHIROPRACTIC & WELLNESS CENTER

INFORMED CONSENT FOR CHIROPRACTIC CARE

Lee Malmstrom, DC Leah Malmstrom, DC
Rex Jones, DC

1025 5th Ave SE, Spencer, IA 51301

A patient, in coming to Spencer Chiropractic & Wellness Center P.C., gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures if he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The doctors provide a specialized, non-duplicating health care service. Our doctors are licensed in a special practice and are available to work with other types of providers in your health care regime.
I understand that if I am accepted as a patient by a physician at Spencer Chiropractic & Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature if patient is under 18_____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case:

Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident □
Medical Savings Account & Flex Plans □ Other _____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____

SPENCER CHIROPRACTIC
& WELLNESS CENTER

1025 5th Ave SE
Spencer, IA 51301
Lee Malmstrom D.C.
Leah Malmstrom D.C.

Print Full Name _____ **Do you have any changes to Insurance Y / N**

Is this visit being submitted to an accident insurance policy (Aflac, Combined or Colonial)? Y/N

If yes, date of injury: _____ Injury: _____

Reason for your visit _____

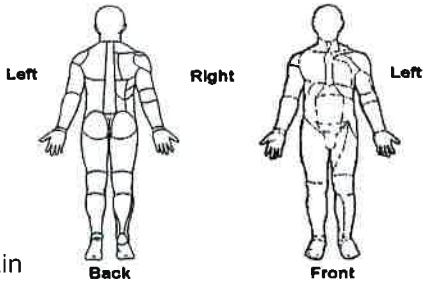
Rate the Severity of Your Pain (If Any):

No Pain — Mild — Moderate — Severe — Pain as Bad as It Could Be

0 1 2 3 4 5 6 7 8 9 10

Describe the Pain or sensation

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



On the diagram to the left, please mark the areas where you are presently having a complaint.

Pain Intensity
- ☐ 0 No pain
- ☐ 1 Mild Pain
- ☐ 2 Moderate Pain
- ☐ 3 Severe Pain
- ☐ 4 Worst Possible Pain

Frequency of pain:
- ☐ 0 No pain
- ☐ 1 Occasional pain 25% of the day
- ☐ 2 Intermittent pain 50% of the day
- ☐ 3 Frequent pain 75% of the day
- ☐ 4 Constant pain 100% of the day

Sleeping:
- ☐ 0 Perfect
- ☐ 1 Mildly disturbed
- ☐ 2 Moderately disturbed
- ☐ 3 Greatly disturbed
- ☐ 4 Totally disturbed

Personal care (washing, dressing, etc.):
- ☐ 0 No pain/no restrictions
- ☐ 1 Mild pain/no restrictions
- ☐ 2 Moderate pain/need to go slowly
- ☐ 3 Moderate pain/need some assistance
- ☐ 4 Severe pain/need 100% assistance

Travel (driving, flying, etc.):
- ☐ 0 No pain on long trips
- ☐ 1 Mild pain on long trips
- ☐ 2 Moderate pain on long trips
- ☐ 3 Moderate pain on short trips
- ☐ 4 Severe pain on short trips

Work
- ☐ 0 Can do usual plus unlimited extra work
- ☐ 1 Can do usual/no extra
- ☐ 2 Can do 50% of usual
- ☐ 3 Can do 25% of usual
- ☐ 4 Cannot work

Recreation:
- ☐ 0 Can do all activities
- ☐ 1 Can do most activities
- ☐ 2 Can do some activities
- ☐ 3 Can do a few activities
- ☐ 4 Cannot do any activities

Lifting:
- ☐ 0 No pain with heavy weight
- ☐ 1 Increased pain with heavy weight
- ☐ 2 Increased pain with moderate weight
- ☐ 3 Increased pain with light weight
- ☐ 4 Increased pain with any weight

Walking:
- ☐ 0 No pain any distance
- ☐ 1 Increased pain after one mile
- ☐ 2 Increased pain after one half-mile
- ☐ 3 Increased pain after one quarter-mile
- ☐ 4 Increased pain with all walking

Standing:
- ☐ 0 No pain after several hours
- ☐ 1 Increased pain after several hours
- ☐ 2 Increased pain after one hour
- ☐ 3 Increased pain after one half-hour
- ☐ 4 Increased pain with any standing

Total Score _____

Signature _____ Date _____