NEWBORN HEALTH FORM (Birth to 2 years)

Date: _____ Child's Home Phone: _____ Social Security #: _____

Child's Name: _____ Sex: **M F** Date of Birth: _____ Age: _____

Child's Home Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Name: _____ Ph #: _____ Relation: _____

Parent/Guardian Name: _____ Ph #: _____ Relation: _____

Person Responsible for Account:

Name: _____ Ph: _____ D.O.B.: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Reason for Today's Visit: _____

When did this problem first occur? _____

The following questions are designed to help the doctor provide a detailed evaluation of your child.

BIRTH HISTORY (Labor & Delivery)

Y N Vaginal Delivery **Y N** Planned C-Section **Y N** Emergency Section

NEWBORN HISTORY

How many hours does your baby sleep between feeds? During Day _____ At Night _____

Y N Does your baby go to sleep easily? _____

Y N Does baby have a preferred sleeping position? Y N Does baby cry if you change sleeping position?

Y N Does baby have any feeding difficulties? _____

Y N Is baby being breast fed? If no, for how long was baby breast fed? _____ (weeks/months)

Y N Does baby have a one-sided breast-feeding preference? If yes which side? Left Right

Y N Is baby formula fed? Which formula or other milk source? _____

Y N Does baby frequently spit-up after feeding?

Y N Does your baby pass a lot of intestinal gas?

Y N Does baby have a preferred head position? **Y N** Does baby frequently arch his/her head and neck backwards?

Y N Does baby cry or become irritable during diaper change? _____

Y N Has baby ever had a fever? **Y N** Has baby had any falls? _____

Y N Has baby had any other trauma? _____

Y N Has your baby/child been vaccinated? _____

INFANT HISTORY (2 months to 2 years)

Health History

Y N Has your child had colic? _____ Y N Has your child had asthma? _____

Y N Has your child had any upper respiratory infections? If yes, how often? _____

Y N Does your child complain of pains in the arms or legs? Y N Does your child ever complain of headaches?

Y N Has your child had any earaches? Y N Does your child's earaches tent to occur in the same ear? **Rt Left Both**

Y N Has your child had any other illnesses? Please list each illness and approximate date:

_____

Y N Is your child presently receiving any medications? _____

Y N Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Do you have any other concerns about your child's health? _____

Nutrition

Y N Does your child have any feeding difficulties? _____

Y N Does your child have any digestive disturbances? _____

Y N Does your child have any food allergies? _____

Y N Does your child have any persistent or intermittent skin rashes? _____

Y N Is your child receiving any vitamin supplements? _____

AUTHORIZATION:

I affirm the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the staff to perform the necessary services that my child may need.

Parent or Guardian Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his hands or mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, cold laser therapy or traction may also be used. Exercises may be recommended.

Benefits of chiropractic treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Risks of Remaining Untreated: Delay of treatments allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

_____ (initial) Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

I hereby request and consent to the performance of medical services, examinations, chiropractic adjustments and other procedures (including various modes of physical therapy and diagnostic x-ray), or physical therapy on me (or the patient named below, for whom I am legally responsible) by Shayne Bauer, D.C. and/or other licensed clinic doctors who now or in the future treat me while employed by, are working or associated with, or serving as a back-up doctor, including those working at the clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I understand the above information and guarantee this form was completed correctly to the best of my knowledge; and I also understand my responsibility to inform this office of any changes in medical status. This informed consent will remain in effect unless there are significant changes to my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

Patient Signature: _____ Date: _____

Consent to treat a Minor (Parent Signature): _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

THIRD PARTY AUTHORIZATION OF INFORMATION

(Complete for Minors and/or Guardian or Spouse registering their Spouse or another Adult)

I (We), _____, acknowledge that I (we) have been informed of or have received a copy of this office's notice of privacy practices. This also includes Wisconsin's Consent Law to HIPPA.

I also request that information regarding my account, proposed treatment and care may be discussed with the following individual(s). I may rescind this at any time, by filling out a new form.

_____ NO OTHER INDIVIDUAL

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Signature: _____ Date: _____

Bauer Chiropractic LLC staff should complete if Acknowledgement Form is **NOT** *signed:*

Y N Does patient have a copy of the Privacy Notice?

If answered "No" above, please explain why the patient did not sign and acknowledgement form and Bauer Chiropractic LLC efforts in trying to obtain the patient's signature (check all that apply.)

____ Patient Unable to Comprehend ____ Patient/Legal Representative Left before Signature Obtained

____ Patient Communication Barrier ____ Emergency Admission/Patient Not Present for Registration

____ Legal Representative not Available ____ Patient bypassed Registration – Not Available

____ Other: _____

Staff Signature: _____ Date: _____