CHIROPRACTIC REGISTRATION AND HISTORY FOR INFANTS

PATIENT INFORMATION

Date _____

Patient _____

Parent/Guardian's name(s): _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____

Guardian's email: _____

Guardian's occupation: _____

Guardian's employer: _____

Employer Address _____

Employer Phone _____ ext. _____

Spouse's Name _____

Birthdate _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Cell _____ Home _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

INSURANCE

Subscriber's name: _____

Relationship to subscriber: _____

Insurance Co. _____

ID# _____ Group #: _____

Is patient covered by additional insurance? ☐es ☐o

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

FINANCIAL AGREEMENT AND RELEASE

I understand that I am financially responsible for all charges rendered by Amy Spellmeyer, DC whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Amy Spellmeyer, DC accounts. I acknowledge that I am solely responsible in securing the necessary REFERRALS from my PRIMARY CARE PHYSICIAN. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I have received /read the HIPAA Policies of this office. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

I hereby request and consent to the performance of chiropractic adjustments and other procedures by the doctor of Spellmeyer Chiropractic Inc. I acknowledge that more information can be provided upon my request.

_____

Responsible Party Signature

_____ _____

Relationship Date

PATIENT INFORMATION

Reason for visit _____

What do you hope will happen as a result of this treatment? _____

How was your baby's birth? _____

Cesarean _____ Forceps _____ Vacuum Extractor _____

Resuscitated _____ Intubated _____ NICU _____ Surgery _____

Did you get antibiotics during labor? Yes ___ No ___ Has your baby had antibiotics? Yes ___No ___

Does your baby get diaper rash? Yes ____No _____

If yes, what does it look like and where is it? _____

Has your baby been immunized? Yes ___ No ___ If yes, was there any reaction? _____

How is your baby's disposition? _____

How does your baby sleep? _____

HEALTH HISTORY

What treatment has your baby received? ☐ Cranial sacral ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ Speech ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition

Date of Last: Physical Exam _____ Spinal X-Ray _____ When? _____
Spinal Exam _____ Chest X-Ray _____ When? _____
MRI, CT Scan, Bone Scan _____ When? _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tumors,	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Growths		
Bleeding	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping	☐ Yes	☐ No
Disorders			Hepatitis	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Cough		
Bronchitis	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Other	_____	

How is breast/bottle feeding going? _____
If using formula, which type? _____
If breastfeeding, do you have sore nipples? Yes ____ No ____
Do you add rice cereal or other additive to your baby's bottle? If yes, what do you add? _____
When did you start solids? _____
Is your baby gaining weight well? Yes ____ No ____ Does your baby spit up? Yes ____ No ____
Does your baby prefer one breast or feeding position? Please explain _____

LEVELS OF ALERTNESS
☐ Low
☐ Moderate
☐ High

ACTIVITIES
☐ Rolling over ☐ Standing
☐ Sitting ☐ Walking
☐ Crawling

Injuries/Surgeries your baby has had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name:		
Pharmacy Phone:		