

# PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: \_\_\_\_\_ MOTHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MOTHER'S WORK PHONE: \_\_\_\_\_ MOTHER'S CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ FATHER'S WORK PHONE: \_\_\_\_\_ FATHER'S CELL PHONE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ NUMBER OF SIBLINGS: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_ CURRENT LENGTH: \_\_\_\_\_

THIRD TRIMESTER PRESENTATION: VERTEX \_\_\_\_\_ BREECH \_\_\_\_\_ TRANSVERSE \_\_\_\_\_ FACE/BROW \_\_\_\_\_

TYPE OF BIRTH: NORMAL VAGINAL \_\_\_\_\_ FORCEPS \_\_\_\_\_ CESAREAN \_\_\_\_\_ SUCTION CAP OR VACUUM \_\_\_\_\_

LOCATION: HOME \_\_\_\_\_ BIRTHING CENTER \_\_\_\_\_ HOSPITAL \_\_\_\_\_

PROBLEMS DURING PREGNANCY: \_\_\_\_\_

PROBLEMS DURING LABOR/DELIVERY: \_\_\_\_\_

APGAR SCORES: \_\_\_\_\_ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? \_\_\_\_\_ CYANOSIS (BLUE)? \_\_\_\_\_

CONGENITAL ANOMALIES/DEFECTS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN? \_\_\_\_\_

INFANT FEEDING: BREAST \_\_\_\_\_ BOTTLE \_\_\_\_\_ IF BOTTLE, WHICH FORMULA? \_\_\_\_\_

NUMBER OF HOURS SLEEPING PER NIGHT: \_\_\_\_\_ QUALITY OF SLEEP: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR \_\_\_\_\_

OBSTETRICIAN/MIDWIFE: \_\_\_\_\_

PEDIATRICIAN/FAMILY MD: \_\_\_\_\_

DATE OF LAST VISIT: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

IMMUNIZATION HISTORY: \_\_\_\_\_

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS \_\_\_\_\_ DURING HIS/HER LIFETIME \_\_\_\_\_

PREVIOUS CHIROPRACTOR: \_\_\_\_\_

DATE OF LAST VISIT: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_

INSURANCE/BILLING INFORMATION: \_\_\_\_\_ POLICY #: \_\_\_\_\_

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## AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE \_\_\_\_\_

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.  
X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_

# PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND \_\_\_\_\_ FOLLOW AN OBJECT WITH HIS/HER EYES \_\_\_\_\_ HOLD HEAD UP \_\_\_\_\_  
SIT ALONE \_\_\_\_\_ CRAWL \_\_\_\_\_ STAND \_\_\_\_\_ WALK ALONE \_\_\_\_\_

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKENPOX \_\_\_\_\_ MUMPS \_\_\_\_\_ MEASLES \_\_\_\_\_ RUBELLA \_\_\_\_\_  
RUBEOLA \_\_\_\_\_ WHOOPING COUGH \_\_\_\_\_ OTHER \_\_\_\_\_

HAS THIS CHILD EVER SUFFERED FROM:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> HEADACHES            | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS            | <input type="checkbox"/> NECK PROBLEMS       | <input type="checkbox"/> POOR APPETITE       | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> FAINTING             | <input type="checkbox"/> ARM PROBLEMS        | <input type="checkbox"/> STOMACH ACHES       | <input type="checkbox"/> RUPTURES/HERNIA     |
| <input type="checkbox"/> SEIZURES/CONVULSIONS | <input type="checkbox"/> LEG PROBLEMS        | <input type="checkbox"/> REFLUX              | <input type="checkbox"/> MUSCLE PAIN         |
| <input type="checkbox"/> HEART TROUBLE        | <input type="checkbox"/> JOINT PROBLEMS      | <input type="checkbox"/> CONSTIPATION        | <input type="checkbox"/> GROWING PAINS       |
| <input type="checkbox"/> CHRONIC EARACHES     | <input type="checkbox"/> BACKACHES           | <input type="checkbox"/> DIARRHEA            | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> SINUS TROUBLE        | <input type="checkbox"/> POOR POSTURE        | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> SCOLIOSIS           | <input type="checkbox"/> HYPERTENSION        | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> COLDS/FLU            | <input type="checkbox"/> WALKING TROUBLE     | <input type="checkbox"/> ANEMIA              | <input type="checkbox"/> OTHER _____         |
| <input type="checkbox"/> COLIC                | <input type="checkbox"/> BROKEN BONES        | <input type="checkbox"/> BED WETTING         | <input type="checkbox"/> OTHER _____         |

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> FALL IN BABY WALKER      | <input type="checkbox"/> FALL FROM BED OR COUCH | <input type="checkbox"/> FALL OFF SKATEBOARD OR SKATES |
| <input type="checkbox"/> FALL FROM CRIB           | <input type="checkbox"/> FALL OFF SWING         | <input type="checkbox"/> FALL OFF BICYCLE              |
| <input type="checkbox"/> FALL FROM HIGHCHAIR      | <input type="checkbox"/> FALL OFF SLIDE         | <input type="checkbox"/> FALL DOWN STAIRS              |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS   | <input type="checkbox"/> OTHER _____                   |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_

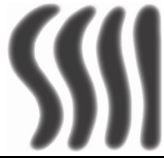
PRESENT HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERY: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ACCIDENTS: \_\_\_\_\_

FAMILY HISTORY: \_\_\_\_\_



## **Patient Consents**

### **Consent for purposes of treatment, payment and healthcare operations**

I consent to the use or disclosure of my protected health information by Raleigh Specific Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Raleigh Specific Chiropractic. I understand that diagnosis or treatment of me by Dr. James Winget or Dr. Jill Winget may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction. Raleigh Specific Chiropractic is not required to agree to the restriction I may request. However, if Raleigh Specific Chiropractic agrees to a restriction that I request, the restriction is binding on Raleigh Specific Chiropractic and on Drs. Winget. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. James/Jill Winget or Raleigh Specific Chiropractic has taken action in reliance on this consent. More information regarding this consent is available upon request.

### **Open adjusting area**

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. Open adjusting involves several patients being seen in the same adjusting area at the same time. Patients are within sight of one another, and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an open adjusting environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Raleigh Specific Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity. Your authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

### **Contact**

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health-related meetings, workshops, missed appointments and appointment reminders. The use of this information is intended to make your experience with our office more efficient and productive, as well as to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Raleigh Specific Chiropractic or on your relationship with our staff.

This office also occasionally posts stories and x-rays of current patients. If this situation presents itself in your case, this office will obtain specific permission from you for that purpose.

Your signature indicates your authorization of this activity. Your authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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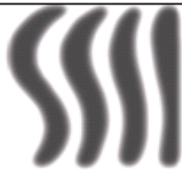
Patient Name, Printed

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Patient Signature

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Date



**Raleigh  
Specific  
Chiropractic**  
Dr. James & Jill Winget

*Chiropractic for pediatric  
development and adult health*

7721 Six Forks Rd.  
Suite 138  
Raleigh, NC 27615  
(919) 846-7004

#### **From 440:**

- Exit 8B (Six Forks North)
- Proceed north approximately 3.5 miles
- (Cross Millbrook/Lynn Rd.)
- Turn Left at 7721 Six Forks Rd. onto Horizon Dr.
- (Enter the Horizon Business Complex)
- We are the 1<sup>st</sup> building on the right
- Take 3<sup>rd</sup> driveway on right and follow around to the back side of the building to Suite #138



#### **From 540:**

- Exit 11 (Six Forks South)
- Proceed south approximately 1.5 miles
- Turn Right at 7721 Six Forks Rd. onto Horizon Dr.
- (Enter the Horizon Business Complex)
- We are the 1<sup>st</sup> building on the right
- Take 3<sup>rd</sup> driveway on right and follow around to the back side of the building to Suite #138