

Newborn Health Questionnaire (Ages 0-1 year)

Name of Child: _____ Today's Date _____ Birthdate _____

Male Female Name of Parents: _____

Address _____
Residence and mailing City State Zip Code

Best Contact Number: (_____) _____ E-mail address _____@_____

Who may we thank for referring you to our office? _____

PREGNANCY HISTORY

Reason for seeking chiropractic care: _____

How long was the labor? _____

Any fertility issues? Y / N If yes, please describe: _____

Did mother exercise? Y / N If yes, please describe: _____

Was mother ill? Y / N If yes, please describe: _____

Any ultrasounds? Y / N If yes, please describe: _____

Please explain any notable episodes of mental or physical stress during pregnancy: _____

BIRTH AND LABOR HISTORY

Place of Birth: Hospital Birthing Center Home

Birth Care Provider: OB/Gyn Midwife Doula

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Long and/or Difficult Labor | <input type="checkbox"/> Fetal Distress |
| <input type="checkbox"/> Abnormal or Breech Presentation | <input type="checkbox"/> Antibiotics Administered | <input type="checkbox"/> Cord Around Neck |
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Forceps | <input type="checkbox"/> Labor Induced |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> Suction Device | <input type="checkbox"/> Rupture of Membranes |
| <input type="checkbox"/> Lack of Fetal Decent | <input type="checkbox"/> Pitocin Administered | <input type="checkbox"/> Lack of Progression |

POST NATAL HISTORY

Please check all that apply for your baby as a newborn:

- | | | |
|--|---|--|
| <input type="checkbox"/> Resuscitation/Oxygen Required | <input type="checkbox"/> Premature | <input type="checkbox"/> Poor Sleeping |
| <input type="checkbox"/> Prolonged Cranial Distortion | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty Nursing/Latching/Sucking |
| <input type="checkbox"/> Low APGAR Score | <input type="checkbox"/> Meconium Aspiration/Stomach Pumped | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Antibiotic Administered | <input type="checkbox"/> Circumcised | <input type="checkbox"/> Colic |

GENERAL HEALTH

Diet History:

Was your baby breastfed? Exclusively Breastfed Previously Breastfed Breastfed and Formula Fed

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

Supplements your baby takes directly: _____

Supplements mom takes if nursing: _____

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

Vaccine Reactions: _____

INFANT HEALTH HISTORY (ROS)

Please check all that apply for your infant:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal Tone | <input type="checkbox"/> Recent Trauma | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> High Pitched Crying | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Poor Weight Gain |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Conjunctivitis |
| <input type="checkbox"/> Poor Eye Control | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Ear Aches/Discharge from Ear |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Tongue Tied | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin Rash/Eczema | <input type="checkbox"/> Diaper Rash |
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Scars | <input type="checkbox"/> Skin Masses/Bumps |
| <input type="checkbox"/> Swelling of Muscles/Joints | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Fall from a High Surface |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Neurological Ticks | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Uncoordinated Movements | <input type="checkbox"/> Cyanosis (blue/purple color) |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Extremity Swelling | <input type="checkbox"/> Abnormal Heart Rhythm |
| <input type="checkbox"/> Food Intolerance: _____ | <input type="checkbox"/> Allergy: _____ | <input type="checkbox"/> Seizures: _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Serious Infection | <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Tenderness | <input type="checkbox"/> Excessive Spitting-up |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Lack of Nursing or Eating | <input type="checkbox"/> Neck or Thyroid Mass |
| <input type="checkbox"/> Abnormal Growth Patterns | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Pain/Difficult Urination |

HIPAA: CONSENT FOR USE FOR DISCLOSURE OF HEALTH INFORMATION

In compliance with federal law, a copy of the national Standards for Privacy of Individually Identifiable Health Information is available upon request. The Privacy Notice describes in detail how a member's health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of a member's health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail. A copy of the Privacy Notice has been made available to me.

When member is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Parent/Guardian_____

Name of Child_____

Date_____

FOR DOCTOR'S USE ONLY



1777 Bunker Lake Blvd NW
Andover, MN 55304
763-413-6934

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a person seeks chiropractic health care and we accept him or her as a patient, it is essential for both to be working toward the same objective. It is important that each member understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis

I, _____ being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature

Date



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