HEALTHPRO
CHIROPRACTIC & ACUPUNCTURE

9720 Cypresswood Drive, Suite 130
Houston, TX 77070

P: 281.809.0100
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Welcome to the Office!

HealthPro Pediatric New Patient Forms Age Infant - School Aged

PATIENT'INFORMATION
Childs Name: _____

Parents/Guardian Name: _____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Parents Phone: _____ **Email:** _____

Childs Birth Date: _____ **Age:** _____ **Gender** □ Male □ Female

Emergency Contact Name: _____

Phone Number: _____ Relationship**:** _____

How were you referred to our office? _____

Pediatrician: _____ **Clinic Name:** _____

Phone Number: _____ **Date and reason of last visit:** _____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He / She is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He / She has a specific condition and I've learned that chiropractic may be able to help. I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *vertebrae.* Many of the common health challenges that adults experience have their origins during the *developmental years,* some starting at birth. Layers of damage to the spine and *nervous system* occur as a result of various ***traumas, toxins****, and* ***emotional stress.*** The result may be misalignment to the spinal column and damage to the nervous system - a condition called ***Vertebral Subluxation****.* Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal****.*

What signals has your child's body been communicating?

Please mark all that apply previously and currently with a ✓

☐ Asthma	☐ Frequent Diarrhea	☐ Failure to Thrive / Slow Weight Gain
☐ Respiratory Tract Infections	☐ Constipation	☐ Slow or Absent Reflexes
☐ Sinus Problems	☐ Flatulence	☐ Asymmetrical Crawling or Gait
☐ Ear Infections	☐ Headaches/Migraines	☐ Weight Challenges
☐ Tonsillitis	☐ Neck Pain	☐ Bed Wetting
☐ Strep Throat	☐ Torticollis / Head Tilt	☐ Sleep Problems
☐ Frequent Colds / Croup	☐ Trouble Feeding on One Side	☐ Night Terrors
☐ Recurrent Fevers	☐ Back Pain	☐ Tip Toe Walking
☐ Eczema	☐ Growing Pains	☐ Sensory Processing Issues
☐ Rashes	☐ Scoliosis	☐ Seizures
☐ Allergies	☐ Red, Swollen, Painful Joint	☐ Tremors / Shaking
☐ Food Sensitivities	☐ Colic	☐ ADD / ADHD
☐ Digestive Problems	☐ Frequent Crying Spells	☐ Autism / PPD

Do you have a specific concern that brings you in?

- ☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.
- ☐ Yes: _____

If Yes please answer the following questions:

Does your child appear to be in pain or discomfort? _____For how long?_____

Is it getting better, worse, or staying the same?_____ Suddenly or gradually?

Have you seen other health professionals regarding this complaint_____

If Yes, whom? _____ What treatment was done? _____

Did you child take medication for this complaint? □ No □ Yes: _____

Has your child ever experienced this before? □ No □ Yes: _____

Is your child currently receiving treatment? □ No Yes: _____

Has you child has any tests for this complaint including x-rays, blood work etc.

_____

Prenatal Profile

□ Adopted □ Prenatal history unknown □ Birth history unknown
Complications during pregnancy: □No □ Yes(brief description): _____
Ultrasounds during pregnancy: □No □ Yes (brief description): _____
Medications during pregnancy: □No □ Yes (brief description): _____
If so which ones and how often? (include OTC): _____
Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: □No □ Yes (brief description): _____

Birth Experience

Location of Birth: □ Home □Hospital □Birthing Center □ Other: _____
Birth Attendants: □ Doula □Midwife □ OB □ Other: _____
Medications during labor / delivery (including IV antibiotics): □ No □ Yes: _____
Was Pitocin used to induce / speed up labor? □ No □Yes
Were your membranes ruptured by a medical professional? □ No □Yes
Was your child at anytime during your pregnancy in a constrained position? □ No □ Yes If yes, please describe: □ Breech □ Transverse □ Face presentation
Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____If it was vaginal, was the baby presented: □ Head □ Face □ Breech
Were any of the following interventions used? □ Forceps □ Vacuum □ Other
Were there any complications during delivery? □ No □ Yes
If yes, please specify: _____
How long was the labor from the first regular contractions to the birth? __ hrs
How long was the second stage (the pushing phase) of the labor? _____ hours
Was the baby born with any purple markings / bruising on their face or head? □ No □ Yes: _____
Any concerns about misshapen head at birth? □ No □ Yes: _____

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____
Birth Weight: _____ Birth Length: _____
Was the baby ever administered to the NICU? □No □ Yes
If yes, for how long and why? _____
Was any medication given to your child at birth? □No □ Yes □ Unsure
If yes, for how long and why? _____
Was your child breastfed □No □ Yes Months: _____
Was your child formula fed? □No □ Yes Months: _____
Did your child show any sensitivity to formula (reflux, eczema, arching back)? □No □
What age did you introduce solid foods to your child? _____months
Did you introduce cereal or grains within your child's first year? □ No □ Yes
Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats etc.) □ No □ Yes Which ones: _____

Physical Traumas

Has your child ever fallen from any high places? □ No □ Yes: _____
Has your child ever been involved in a motor vehicle accident? □ No □ Yes: _
Has your child been seen on an emergency basis? □ No □ Yes: _____
Has your child broken any bones? □ No □ Yes_____
Has your child had any previous hospitalizations? □ No □ Yes: _____
Has your child had any previous surgeries? □ No □ Yes: _____
Does your child use a tablet, computer, or video game? □ Never □ Rarely □ Daily □ Several hrs/day
Does your child watch TV? □ Never □ Rarely □ Daily □ Several hrs/day
Does your child exercise? □ No □ Daily □ Weekly □ Seasonally
Does your child play contact sports? □ No □ Daily □ Weekly □ Seasonally
Does your child sleep on their... □ Back □ Belly □ Sides (both, right, left)
Does your child carry a back pack? □ No □ Yes
Does it weigh less than 15% of their body weight? □ No □ Yes
Do they wear their back pack on 2 shoulders? □ No □ Yes
Does your child show excessive or uneven shoe wearing out? □ No □ Yes
Does your child wear custom orthotics? □ No □ Yes: For what purpose: _____

Chemical Stressors

Have you chosen to vaccinate your child? □ No □ Yes,on schedule □ Yes, delayed schedule
Has your child had any reactions to vaccinations? □ None □ Fever □ Diarrhea □ Rash □ Welt on injection site □ Fatigue □ Seizures □ Prolonged Cry
□ Developmental Regression □ Other: _____
Does your child receive annual flu shots? □ No □ Yes
Has your child taken to antibiotics □ No □ Yes reason and dosage in last 6 months: _____
Has your child taken medications (including OTC) □ No □ Yes reason and dosage in last 6 months: _____
How many glasses of water/day does your child have? □ 0 □ 1-4 □ 5-9 □ 10+
How many glasses of cow's milk, juice, and soda/day? □ 0 □ 1-4 □ 5-9 □ 10+
Does your child eat gluten? □ No □ Yes □ Trying to eliminate
Does your child eat dairy? □ No □ Yes □ Trying to eliminate
Any food/drink allergies or sensitivities? □ No □ Yes: _____
Is your child exposed to second hand smoke? □ No □ Yes: _____
Does your child take a probiotic daily? □ No □ Yes: _____CFU's/day
Does your child take a vitamin D3 daily? □ No □ Yes: _____IU's/day
Does your child take Omega 3 Fish Oils daily? ? □ No □ Yes: _____mg/day
Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: □ Yes □ No: _____

Emotionally: □ Yes □ No: _____

Physically: □ Yes □ No: _____

What is your primary goal for your child at our clinic? _____

_____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation and Treatment of a Minor Child

I _____ (print name) being parent or legal guardian of _____(print name of minor) hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

Consent To Treatments

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment, acupuncture treatment or massage therapy performed by the doctors of HealthPro Chiropractic and Acupuncture and anyone working in the clinic authorized by the above referenced doctors of chiropractic. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by HealthPro Chiropractic and Acupuncture doctors of chiropractic or staff.

_____**INTIAL** I understand that there are risks associated with any treatment. Chiropractic and acupuncture are very low risk procures. Potential risks include slight pain, discomfort or soreness in the area treated. Associated risk factors for acupuncture include but are not limited to the following: bruising, blistering, bleeding, redness around the site where the needle was inserted, weakness, fainting, nausea, temporary discoloration of the skin, possible aggravation of the symptoms existing prior to treatment, skin infection or broken needle.

_____ _____

Consenting Adult Signature Date

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AGREEMENT AND INSTRUCTION FOR DIRECT PAYMENT BY PRIVATE AND GROUP OR ACCIDENT AND HEALTH INSURANCE

RE: Patient: _____ Insured: _____

Employer: _____

Group / Claim #: _____

S.S. or ID#: _____

I hereby instruct and direct the _____
Insurance Company or Law Office to pay by check made out and mailed directly to:

HealthPro Chiropractic and Acupuncture

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Or, if my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

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The medical expenses benefits allowable under my health or PIP policy, and otherwise payable to me under my current insurance policy as payment toward the total charges for chiropractic services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance for chiropractic service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to you as the insurance company or attorney.

Dated this _____ day of _____, 20_____

Policyholder _____

Patient Signature _____

Witness _____

***** Please note most insurance companies will not cover pediatric chiropractic services. HealthPro does offer affordable cash prices.***

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Patient Provider Email Agreement

Name:
Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has the advantages over office visits or telephone calls. But remember, there are also important differences. Email is not the same as calling our office, there is no person at the other end of the call – just a computer. You can't tell for certain when your messages will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication that email affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via email.

- Email is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- Email is great for asking those little questions that don't require a lot of discussion. Appropriate uses of email also include referral letters, excuse notes needed for work/school after an appointment, and billing/insurance questions.
- Emails should not be used to communicate sensitive information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Email is not confidential. It is like sending a postcard through the mail. Our staff may read your emails to handle routine, non-emergency matters. You should also know that if sending emails from work, your employer has a legal right to read your email if he or she chooses.
- Email may become a part of the medical record when we use it, a copy may be printed and put in your chart.
- Email is not a substitute to seeing a doctor at HealthPro. If you think that you may need to be seen, please call and schedule an appointment.
- Emails may be forwarded to our staff for handling, if appropriate.

Finally, HealthPro reserves the right to revoke permission of the email system at any time.

☐ I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security of information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state of which my doctor is licensed.

PATIENT:
Patient Name: _____
Patient Signature: _____
E-Mail Address: _____
Date: _____