Colburn Chiropractic

Phone: (860) 870-4100

131 New London Tpke, Suite 302
Glastonbury, CT 06033

Marla Colburn, DC

PEDIATRIC PATIENT INFORMATION

Child's Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Referred to Office by: _____

Home Phone: (____) _____ - _____

Parent's Name: _____ Work Phone: (____) _____ - _____

Parent's Name: _____ Work Phone: (____) _____ - _____

Primary Insurance Company:_____

Insured's Name: _____

Membership/ Insured's ID#: _____ Group #: _____

Insured's Relationship to Patient: _____

Insured's Address: _____

Insured's Date of Birth: _____ Insured's Soc Security #: _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to Marla Colburn, DC and I understand I am financially responsible for any and all non-covered services provided by Marla Colburn, DC.*

Signature: _____ Date: _____

Reason for Today's visit: "Wellness Exam" or describe the complaint, when was its onset?

_____

_____

Duration: _____ Frequency: _____

What makes it worse? _____

What makes it better? _____

How does your child communicate the problem?_____

_____

Who is your pediatrician? _____

Has your child been seen for this complaint? _____

Has your child had any X-rays taken for this or other conditions? ( ) No ( ) Yes

When? _____

Facility? _____

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Name: _____ Date:_____

Has your child undergone any surgery? _____

_____

Has the child ever received chiropractic care? ( ) No ( ) Yes

Chiropractor's Name _____

Treatment _____

CLINICAL HEALTH HISTORY

Pregnancy History

a) Number of pregnancies: 1 2 3 4 5 _____

b) Any miscarriages: ( ) None ( ) Yes [how many? _____]

c) Any stillbirths: ( ) None ( ) Yes [how many? _____]

d) Was this pregnancy an in vitro fertilization? ( ) No ( ) Yes

e) Was this pregnancy an artificial insemination? ( ) No ( ) Yes

Prenatal

a) Did mother receive chiropractic care during pregnancy? ( ) No ( ) Yes

b) Did mother receive prenatal care? ( ) No ( ) Yes

c) Did mother go to prenatal classes for this pregnancy? ( ) No ( ) Yes

d) Duration of pregnancy: (months) 6 7 8 9 10 _____ weeks

e) Mother's health: ( ) Healthy ( ) Minor illness ( ) Serious illness

Please explain:_____

Was the mother exposed to any of the following:

( ) X-rays ( ) Smoke: _____ Packs/day ( ) Alcohol ( ) Caffeine

( ) Medication:_____ By:_____

( ) Ultrasound: Trimester _____ Number of times _____

Reason:_____

( ) Amniocentesis: Trimester _____ Number of times_____

Reason: _____

( ) Chronic Villi sampling: Trimester _____ Number of times_____

Reason: _____

( ) Prenatal vitamins w/ iron _____

f) Mother's nutritional status: ( ) Good ( ) Poor ( ) Vegetarian/Vegan ( ) Junk food eater

g) Mother's attitude: ( ) Relaxed ( ) Anxious ( ) Emotional ( ) Excited

( ) Other: _____

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Natal

a) Labor: number of hours _____ ( ) Difficult ( ) Uncomplicated

Was labor induced? ( ) No ( ) Yes

b) Delivery: ( ) Vaginal ( ) C-Section ( ) Forceps ( ) Complicated

( ) Vacuum ( ) Anesthesia: Drug _____

Emotional state of mother: _____

c) Place of birth: ( ) Hospital ( ) Home ( ) Birthing center

( ) Other: _____

d) Present at birth: ( ) Physician ( ) Nurse Midwife ( ) Lay midwife

e) Birth weight: _____ Lbs _____ Ozs Length: _____inches

f) Condition of child after birth: ( ) Good ( ) Fair ( ) Poor

APGAR Scores: At 1 minute _____ At 5 minutes _____

g) Congenital anomalies/ defects _____

_____

Neonatal

( ) Fever ( ) Convulsions ( ) Cyanosis (blue) ( ) Jaundice (yellow)

( ) Infections ( ) Rash ( ) Breathing Problems ( ) Suckling difficulty

( ) Club feet ( ) Anomalies _____

Infancy

a) Nutrition: ( ) Breast fed [How long?_____]

( ) Bottle formula_____

( ) Allergies to formula _____

b) Digestion: ( ) Colic ( ) Projectile vomiting ( ) Excess crying

( ) Other: _____

c) Introduction to solid foods: _____

Allergies: _____

Favorites: _____

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Name: _____ Date:_____

REVIEW OF SYSTEMS

Current Problems (within past 3 months)

1) Special senses: ( ) No Problems ( ) Smell ( ) Sight ( ) Hearing ( ) Speech ( ) Touch

2) Dentition: ( ) No Problems ( ) Cavities ( ) Discolored teeth ( ) Braces
( ) Special Dental Care _____

3) Cardiovascular: ( ) No problem ( ) Dyspnea ( ) Cyanosis (blue) ( ) Edema
( ) Precordial pain ( ) Syncope ( ) Murmur

4) Respiratory: ( ) No Problem ( ) Cough ( ) Congestion ( ) URI's ( ) Ear infections
( ) Allergies _____

5) Genitourinary: ( ) No Problem ( ) Enuresis ( ) Diuresis ( ) Yeast

6) Nervous system: ( ) No problem ( ) Convulsion ( ) Nervous ( ) Stare ( ) Seizures
( ) Restless ( ) Very sound ( ) Sleepwalks ( ) Nightmares
( ) Gets up often # Hrs sleep/night:_____

7) Musculoskeletal: ( ) No problem ( ) Muscle weakness ( ) Paresis ( ) Paralysis
( ) Spastic ( ) Palsy ( ) Hypotonia ( ) Growth spurts ( ) Joint pain
( ) Spinal curves _____

8) Gastrointestinal: ( ) Constipation ( ) Diarrhea ( ) Irritable ( ) Ulcer ( ) Reflux
( ) Intusseseption

A) # bowel movements/ day_____ ( ) Small ( ) Large ( ) Hard ( ) Soft
( ) Dark ( ) Light ( ) Floats in toilet

B) Appetite: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Attitude towards food: _____

C) Supplements: _____

Growth and Development: Current Height _____ Current Weight_____

Developmental Milestones:

( ) Respond to sound at _____ mos.

( ) Follow object with eyes at _____mos.

( ) Head control _____ mos.

( ) Sit at _____ mos.

( ) Crawl at _____ mos. ( ) walk at _____ mos.

( ) Abnormal crawl: _____

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Name: _____ Date:_____

Sleep Patterns: At what age did the child begin to sleep through night? _____

( ) Sound ( ) Restless ( ) Nightmares ( ) Talks ( ) Walks

Toilet trained: ( ) Yes[at ___ years old] ( ) No [Difficulty_____]

Habits: ( ) Nail biting ( ) Rocking ( ) Tantrums ( ) Thumb sucking

( ) Head banging ( ) Masturbation ( ) Pica

Sexual Development: ( ) Secondary sex characteristics [year of appearance _____]

( ) Menarche [year of appearance _____]

( ) Attitude _____

Discipline: ( ) WNL ( ) Tantrums ( ) Aggressive ( ) Violent

( ) Withdrawn ( ) Destructive _____

School Adjustment:

( ) Separation anxiety ( ) Independent ( ) Shyness ( ) Friendly

( ) Hobbies: _____ ( ) Sports: _____

H. Eating Habits: # of meals/ day: _____

( ) Picky ( ) Constantly ( ) Junk ( ) NutraSweet ( ) Sweet ( ) Salty

Picky about certain textures: _____

Favorites: _____

FAMILY HEALTH HISTORY

Birth order of child? _____

Family status at child's birth? _____

Current status? _____

Do all family members reside at same address? _____

1) Natural mother's age: _____ Health: ( ) Good ( ) Under Doctor's care

( ) Chronic illness ( ) Mental health care

( ) Emotional instability ( ) Surgeries:_____

_____

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Name:_____ Date:_____

2) Natural father's age: _____ Health: ( ) Good ( ) Under Doctor's care

( ) Chronic illness ( ) Mental health care ( ) Emotional instability

( ) Surgeries:_____

_____

3) Sibling's health:

Name Age Health

#1_____

#2_____

#3_____

#4_____

#5_____

Family History (P) = Paternal; (M) = Maternal; (P/M) = Both sides

( ) Allergies ( ) Blood Dyscrasias ( ) Cancer ( ) Diabetes ( ) Epilepsy

( ) Congenital Anomalies ( ) Tuberculosis ( ) Heart Disease ( ) Mental Illness

( ) Hypertension ( ) Kidney Disease ( ) Autism ( ) Hyperactivity ( ) Liver Disease

( ) Ulcer ( ) Chronic Colds ( ) Behavior disorders ( ) Asthma ( ) Chronic Flu

( ) Colic ( ) Learning Disorders ( ) Enuresis ( ) Cerebral Palsy ( ) Strokes

( ) Chronic Otitis Media ( ) Hernia ( ) Leukemia ( ) Arthritis ( ) Difficulty Breastfeeding

( ) Nervous Disorder ( ) Other_____

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Date

_____

Signature

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care is a system of health care delivery. As with many health care disciplines, we cannot promise a cure for any symptom, disease or condition as a result of treatment. We will promise to give you our best to achieve good health and well-being the natural way.

The doctor will primarily provide chiropractic adjustments or manipulation during the course of treatment. This is done with the use of his/her hands and/or a mechanical device upon your body in order to move your joints in certain directions. This procedure may cause a "pop" or "click" to be heard from the area treated and should not be a cause for alarm. There are some material risks involved in these procedures and include:

1. Pain: Treatment may result in temporary increased soreness in the area treated.
2. Rib fractures: These are rare and may occur in patients with osteoporosis or weakened bones. Evidence of osteoporosis or weakened bones may be noted on x-ray. If detected, treatment is modified to assure a gentle and effective adjustment is provided. Gentle treatment is applied to all patients. Specialized care is provided to young, frail, and elderly individuals.
3. Disc injury: Chiropractic treatment is appropriate for many types of spinal related conditions, including disc conditions. Occasionally, treatment may aggravate a problem if the disc is in a severely weakened state. This occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at one per 100 million spinal manipulations.
4. Stroke: The incidence of stroke in the general population is 2 per 1000 people. Manipulation of the neck has been implicated as a cause for stoke in the past. Upon review of the literature and data, the incidence is one per 5 million manipulations. Usually, the type of manipulation is violent, not specific, to the area requiring treatment and delivered by a non-chiropractic provider. In comparison, the risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen, motrin, etc) is 4 per 100,000 patients. The risk of serious complications or death from spinal surgery of the back is 11.25 per 1000 patients. The risk of chiropractic treatment is far less than the risk of medical and surgical treatment. Even though the risk of injury is very low, we include procedures and tests that may help us reduce the potential for stroke or other complications.
5. _____

_____

_____

I (We)_____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on_____, by COLBURN CHIROPRACTIC, LLC and/or other licensed doctors of chiropractic or other health care providers who may be employed by or engaged in practice of their respective discipline in the office of COLBURN CHIROPRACTIC, LLC.

I have had an opportunity to discuss with the doctor, or other clinical personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result may not necessarily indicate error in judgment; that no guarantee as to results has been made to nor relied upon me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but ate not limited to, fractures, disc injuries, strokes, dislocations and sprains, and which may be related to physical aberrations unknown to or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the named procedures.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	
Parent/ Guardian Name	Parent/ Guardian Signature	