Patient Demographics Form

Date: _____/_____/__________

Patient Name: ______________________________ _____ _____________________________________
First MI Last

Date of Birth: ____/____/_______ Sex: M / F

Parent/Guardian Name: ______________________ _____ ___________________________________
First MI Last

Street Address: ____ Home Phone: ___________________

City: ________________________________State_____ Zip _________ Mobile Phone: ________________

Email Address: ____________________________________

Family Physician's Full Name: ____

PATIENT RESPONSIBILITY

I understand that Dr. Tammy Watkins and Dr. Nicole Shabino are non-participating physicians, and as such, will not bill my insurance company, should I have insurance that covers chiropractic care. All payments for my care are due at the time of service.

Birthwell has my permission to contact me the following ways:

___ May leave message on my home answering machine ___ May call my cell phone ___ May call me at work
___ May make a reminder call for appointments ___ May email me: ______________________________

x ____ ______________________________
Signature of Patient or Legal Representative Date

If patient is under the age of 18:

Full Name of Parent or Legal Representative: ____

Address if different than your own: ____

City ________________________________State _____ Zip __________ Day Phone ______________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

My signature below indicates that I have been given an opportunity to read Birthwell's "NOTICE OF PRIVACY PRACTICES" and to have any questions answered before signing.

Signed: ____Date ____________________

Print Name: ____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient

For OFFICE USE ONLY: Employee Signature:_______________________________________Date______________

[ ] Efforts to Obtain: ____

[ ] Reason patient refused to sign: ____

Prenatal Chiropractic

Date: ___/___/_____

Child's Name: ____ DOB: ___/___/____
Parent's/Guardian's Names: ____
Has your child been checked by a Doctor of Chiropractic? □ **Yes** □ **No** Name: ________________________
Were x-rays taken? □ **Yes** □ **No**
Who is your medical pediatrician?____

***Prenatal History*:**
Is your child adopted? □ **Yes** □ **No**
Did you have any complications and when? ____
Did you smoke/consume alcohol/use recreational drugs? □ **Yes** □ **No** ____________________________________
Did you take medication? □ **Yes** □ **No** Reason: ____

***Birth history*:**
Did you have ultrasound during this pregnancy? □ **Yes** □ **No** Frequency____________________________________
Place of birth: □ Home □ Birthing Center □ Hospital
Provider: □ Midwife □ OB/Gyn □ Other (Name): ____
Type of Birth: Vaginal / C-section. Were pain medications used? □ **Yes** □ **No** Type ______________________
Was labor induced? □ **Yes** □ **No** If yes, why? ____
What position did you deliver in: □ Squatting □ On Back □ Other _______________________________________
Birth Trauma: □ Doctor-assisted □ Twisting and/or Pulling □ Vacuum Extraction □ Forceps
Newborn trauma (medical procedures and tests): ____
APGAR score: at birth ___ /10 at 5-minutes ___ /10 □ Unsure
Did your child have a misshaped skull/head? □ **Yes** □ **No** Purple markings on their face? □ **Yes** □ **No**

Do you/Did you breastfeed your child? □ **Yes** □ **No** If yes, for how long?_______________________________
Does your child prefer one breast/side over the other? □ **Yes** □ **No** Which side?: □ **Right** □ **Left**
Does your child have any food or other allergies? (list) ____

Has your child been immunized according to the recommended schedule? □ **Yes** □ **No**
Reason for vaccination: informed decision, didn't know had a choice, recommended
Did your child have any negative reactions to vaccinations? □ **Yes** □ **No** _________________________________
Were they reported? □ **Yes** □ **No**

Has your child been evaluated by a lactation consultant? □ **Yes** □ **No**
Has your child been diagnosed with a lip and/or tongue restriction? □ **Yes** □ **No**
Has your child had a lip/tongue tie release procedure? □ **Yes** □ **No**

Has your child ever had any surgeries? □ **Yes** □ **No** Please explain: ___________________________________
Have they been on antibiotics? □ **Yes** □ **No** How many times? ________ Reason: ______________________
Is your child currently taking any medications? □ **Yes** □ **No** ____
Any vitamins? □ **Yes** □ **No** ____

***Baby/Toddler (0-4)*:** have/did any of the following occur?
□ Fall from a changing table
□ Tumble down stairs
□ Fall out of crib
□ Involvement in MVA
□ Fall off of playground equip
□ Play in a Johnny jumper
□ Frequent crying spells
□ Frequent fevers
□ Frequent bouts of diarrhea
□ Constipation
□ Sleeping problems
□ Repeated infections or colds
□ Frequent ear infections
□ Tonsillitis
□ Colic
□ Reaction to vaccines
□ Inadequate weight gain
□ Other: ________________________

Please explain: ____
____

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Prenatal Chiropractic

Child (5-12): have/did any of the following occur?

- □ Fall from a tree
- □ Fall off of a bicycle
- □ Sports accident
- □ Car accident
- □ Stomach pains
- □ Scoliosis
- □ Bed wetting
- □ Fall on playground
- □ Hyperactivity/autism
- □ Learning difficulties
- □ Asthma
- □ Allergies
- □ Leg/knee pains
- □ Other: ______________________

Please explain: ____
____

Adolescents: have any of the following occurred?

- □ Headaches
- □ Dizziness
- □ Ringing in ears
- □ Asthma
- □ Hyperactivity
- □ Fatigue
- □ Numbness in arms/hands
- □ Numbness in legs/feet
- □ Sleeping problems
- □ Allergies
- □ Stomach problems
- □ Weight gain/loss
- □ Arm/wrist pain
- □ Foot/ankle/knee pain
- □ Neck/back pain
- □ Shoulder pain
- □ Growing pains
- □ Other: ____________________________

Please explain: ____
____

Daily Living:

Which of the above bothers your child the most? ____

When did it begin? ____

Is it getting worse? □ **Yes** □ **No**

Is the pain: □ constant □ intermit □ cyclical

How much has the complaint affect daily activities/routines? □ Not at all □ Somewhat □ Frequently □ Always

Which sports does your child play? □ Soccer □ Football □ Gymnastics □ Karate □ Hockey □ Lacrosse □ Basketball □ Dance □ Wrestling □ Baseball/ Softball □ Volleyball □ Tennis □ Swimming □ Rugby □ Other: ____

How would you rate your child's diet? □ Well balanced □ Average □ High amounts sugar & processed food

Does your child consume artificial sweeteners? □ **Yes** □ **No** Fluoridated water? □ **Yes** □ **No**

Number of hours your child sleeps? ____/day Quality of sleep: □ Good □ Fair □ Poor

Is there anything else we should know about your child? ______________________________________
____
____

Authorization to Treat a Minor

I, ______________________________, the undersigning parent/person having legal custody/guardianship of ___________________________, a minor, do hereby authorize, request and direct Dr. Tammy Watkins and/or Dr. Nicole Shabino and whomever they may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

PATIENT: ______________________________________ Date of Birth: _________________
Name (Print)

Signature: _____________________________________ Date: ________________________
Parent/Legal guardian

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PATIENT NAME: ______________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to the possible following procedures: Spinal manipulative therapy, palpation, range of motion testing, muscle strength testing, postural analysis, Kinesio taping, electrical muscle stimulation, and/or ultrasound therapy.

The material risks inherent in chiropractic adjustment.
As with any healthcare producer, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myclopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious compilations including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described are rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postpones.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Tammy Watkins and/or Dr. Nicole Shabino and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

____   _______________________
Patient Signature   Date

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