PRIOUX CHIROPRACTIC

7650 Anchor Dr. Port Arthur, TX 77642

INFANT CHIROPRACTIC INTAKE FORM

Name of Child: ________________________________ Date: ______________

Date of Birth: ____________________________ Gender: Male ☐ Female ☐

Name of Parent/Guardian: __________________________ Phone ______________

Address: ______________________City: ___________ State: ______Zip: _________

Reason for today's visit? ____

Date of last pediatrician appointment/reason? ______________________________

Any health concerns? ____

Has your child undergone care for any conditions? (please list medications)

____

Birth Location: Home Birth ☐ Birth Center ☐ Hospital Birth ☐

Provider: Midwife ☐ OBGYN ☐

Duration of pregnancy: _______weeks

Induced labor ☐ C-Section ☐ Vacuum ☐ Forceps ☐

Birth Weight: _______ Length: _______ Duration of Labor/active labor: __________

Any medications during labor/delivery: _______If so, what kind: _________________

Any complications with birth? _______ If yes, please describe: __________________

____

Do sleeping patterns seem normal to you? _____ If no, please explain. ____________

____

How many wet diapers in a day? _____ How many dirty diapers in a day? _______

What is baby's diet like? (Breastfeeding times, oz of milk, formula, solids, etc.)

____

SINCE THE HEALTH OF THE NERVOUS SYSTEM CAN BE AFFECTED BY MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS <u>VERY IMPORTANT</u>.

CHEMICAL STRESSORS (Childs age may not apply to parts of this section)

Was baby breast fed? Yes ☐ No ☐ For how long? ______________________

Was formula ever introduced? Yes ☐ No ☐ What age/type of formula? ____________

Was there introduction of cow's milk? Yes ☐ No ☐ What age? ____________

Food/Juice intolerance? Yes ☐ No ☐ If Yes, what type? ______________________

Did mother smoke during pregnancy? Yes ☐ No ☐

Did mother drink alcohol? Yes ☐ No ☐

Any illness of mother during pregnancy? Yes ☐ No ☐

Any drugs taken during pregnancy? Yes ☐ No ☐

Any invasive procedures (amniocentesis, CVS?) Yes ☐ No ☐

Was baby vaccinated at birth? Yes ☐ No ☐ If yes, which ones? ________________

Any reactions to vaccines? Yes ☐ No ☐ If yes, what kind? ______________________

Any antibiotics since birth? Yes ☐ No ☐ If yes, what kind? ______________________

PSYCHOSOCIAL STRESSORS (Childs age may not apply to parts of this section)

Any difficulties with nursing? Yes ☐ No ☐ If yes, what kind? __________________

Any behavioral problems? Yes ☐ No ☐ If yes, what kind? ______________________

Any night terrors, sleepwalking, bed wetting? Yes☐ No ☐ Explain: __________

TRAUMATIC STRESSORS (Childs age may not apply to parts of this section)

Any traumas during pregnancy (falls/accidents) Yes☐ No☐ If yes, what kind? __________

Any birth trauma? (bruises, odd shaped head, stuck in birth canal, excessively long birth, respiratory depression, cord around neck, other?) Yes ☐ No ☐ If yes, what kind? ________

Any falls from couches, bed, changing tables? Yes ☐ No ☐ If yes, what kind? __________

Any Hospitalizations? Yes ☐ No ☐ If yes, please explain: ______________________

Any surgeries? Yes ☐ No ☐ If yes, please explain: ______________________________

Has your child ever seen a Chiropractor? Yes ☐ No ☐ Name of Chiropractor:__________

MILESTONES:

1-3 MONTHS:

Supports head and upper body when on stomach? Yes ☐ No ☐

Stretches out legs and kicks when on back or stomach? Yes ☐ No ☐

Opens and shuts hands? Yes ☐ No ☐

Grabs and shakes toys? Yes ☐ No ☐

Follows moving objects with eyes? Yes ☐ No ☐

Turns head to sound of stimulus? Yes ☐ No ☐

Makes cooing sounds? Smiles at familiar faces? Yes ☐ No ☐

4-7 MONTHS:

Rolls over both stomach to back & back to stomach? Yes ☐ No ☐

Sits up with/without support? Yes ☐ No ☐

Reaches for objects? Yes ☐ No ☐

Transfers objects from hand to hand? Yes ☐ No ☐

Supports whole weight standing? Yes ☐ No ☐

Explores objects with hands and mouth? Yes ☐ No ☐

Laughs? Babbles consonants? Yes ☐ No ☐

8-12 MONTHS:

Gets in and out of sitting position independently? Yes ☐ No ☐

Gets on hands and knees position to crawl? Yes ☐ No ☐

Pulls self up to standing/walks along furniture? Yes ☐ No ☐

Holding spoon or book by themselves? Yes ☐ No ☐

Says "mama" and "dada" referring to parent? Yes ☐ No ☐

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other ____________________

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: ____

____

____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
print name

____
signature of patient

____
date signed

To be completed by the patient's representative:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as: ____________________
relationship/authority of patient's representative

____
date signed

To be completed by doctor or staff:

____
witness to patient's signature

____
date

____
translated by

____
date

PRIOUX CHIROPRACTIC CENTER
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

________________________________ ____________________

Signature of Patient of Representative Date

____

Printed Name

PRIOUX CHIROPRACTIC

DR. DAVID PRIOUX JR. | DR. LUCIE LOK

CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name ____

Birthdate: ____________________ Age: _____

Parent/Guardian Name(s): ____

Telephone(s):

Home: ____________________

Cell(s) ____________________

Work: ____________________

Employer: ____________________

I, [print name], ______________________________, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Prioux Chiropractic Center. This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Prioux Chiropractic Center IN WRITING of my intent to withdraw consent.

SIGNED [today's date]: ____

Parent/Legal Guardian Signature: ____

Printed Name: ____