UprightHealth
MUSCLE & JOINT CARE

General Information

Patient Name:_____

Date of Birth:_____

Parent's Name:_____

Address:_____

City:_____

State:_____ Zip:_____

E-mail:_____

Phone:_____ ☐ Cell ☐ Home

How did you hear about/find us?_____

_____

Is this your child's first visit to a Chiropractic Physician?

☐ No ☐ Yes

Emergency Contact Info

Name:_____

Relationship:_____

Phone:_____ ☐ Cell ☐ Home

Pre-Natal History

Is this your biological child? ☐ Yes ☐ No

Did you smoke or drink on any regular basis during this pregnancy? ☐ Yes ☐ No

Please list any complications you experienced with this pregnancy:_____

_____

_____

Please list any prescription medications you took during this pregnancy:_____

_____

_____

_____

Birth History

What type of environment was this child born in?

☐ Home ☐ Birth Center ☐ Hospital ☐ Other

Who delivered this child?

☐ Midwife ☐ Medical Doctor ☐ Other

What type of delivery did you have?

☐ Vaginal Birth ☐ Assisted Vaginal Birth ☐ C-Section

Was anesthesia used? ☐ Yes ☐ No

Was there need for an Induction? ☐ Yes ☐ No

Please share any other notable details about this child's birth:

_____

_____

_____

Health History

How is/was this child fed as an infant?

☐ Breastfeeding ☐ Bottle-feeding ☐ Both

Which vaccines has this child received?

☐ Hepatitis B ☐ Rotavirus ☐ DTap ☐ Hib ☐ PVC

☐ IPV ☐ Influenza ☐ MMR ☐ Varicella ☐ Hep-A

Please describe any notable adverse vaccine reactions:

_____

_____

_____

Dr.'s Notes

Health History continued…

Recent signs & symptoms: (Please check all that apply.)

- ☐ Colic
- ☐ Ear Infections
- ☐ Constipation
- ☐ Excessive Vomiting
- ☐ Fall or Injury
- ☐ Sore Throat
- ☐ Loss of Appetite
- ☐ Excessive Diarrhea
- ☐ Fever
- ☐ Sleeplessness
- ☐ Irregular Breathing
- ☐ Use of Jumper or Bumbo
- ☐ Scoliosis
- ☐ Bed Wetting
- ☐ ADD/ADHD
- ☐ Autism/Asperger's

Please list any injuries, hospitalizations or surgeries, with approximate dates:

Please describe your child's eating habits:

Please describe your child's physical/sports activities:

Medications

Supplements

Allergies

Dr.'s Notes

Authorization to Provide Care

As their legal guardian, I authorize the physicians at Upright Health Muscle & Joint Care to administer manual manipulations, advanced soft tissues techniques, passive therapies and/or any treatment deemed appropriate for the minor child listed above, for the purposes of regaining and/or maintaining musculoskeletal health, unless I expressly refuse beforehand.

Parent/Guardian Signature	Relationship	Date

Receipt of Notice of Privacy Practices

I have been offered a copy of Upright Health Muscle & Joint Care's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at www.uprighthealth.us/npp.pdf

Initial:_____

Payment Policy

I understand that payment for services rendered, per the fee schedule listed at http://uprighthealth.us, will be due on the date of service and accepted in the forms of cash, check or charge. I may choose to submit a reimbursement claim directly to my insurance provider. UprightHealth will supply any additional documentation regarding my treatment, needed for this purpose, at my request.

Initial:_____