

# Infant Registration & History

Dr. J Chris Chlebowski, Chiropractic Physician  
923 NE Couch Street  
Portland, OR 97232

## Patient Information

Today's Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Phone Number: \_\_\_\_\_

Previous Chiropractic Care?  Y  N

Referred By: \_\_\_\_\_

Patient under the care of another physician?  Y  N

If yes, who? \_\_\_\_\_

## Phone Numbers

Emergency Contact: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_

Pediatrician's Phone #: \_\_\_\_\_

## Insurance Information

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

## Responsible Party Information

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Other Information

Marital Status of Child's Parents: \_\_\_\_\_

With Whom Does the Child Reside: \_\_\_\_\_

## Authorization for Care of a Minor

I hereby authorize this office to administer care for my daughter/son as they deem necessary. I clearly understand that I am responsible for all fees charged by this office.

Parent or Guardian Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature Date: \_\_\_\_\_

To help us serve you better, please complete all of the following information. We look forward to working with you to build better health for you and your family.

# Infant Health History

Patient Name: \_\_\_\_\_

What are your reasons for bringing your child into the office today?

Has your child seen any other physicians for this/these conditions?

Y  N

Name of physician and prior treatment(s):

When did this/these complaints begin? \_\_\_\_\_

Check any of the following conditions your child has suffered from:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Cradle Cap	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Breast Feeding Issues	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Seizures
<input type="checkbox"/> Rubella	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Colic
<input type="checkbox"/> Bruising	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Edema	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Hip Dislocation	<input type="checkbox"/> Mumps	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Rash
<input type="checkbox"/> Other: _____				
<input type="checkbox"/> Car Accidents: <i>Please explain in detail</i>				
_____				
<input type="checkbox"/> Traumas/Falls: <i>Please explain in detail</i>				
_____				
<input type="checkbox"/> Hospitalizations/Surgeries: <i>Please explain in detail</i>				
_____				
<input type="checkbox"/> Allergies: <i>Which ones and how did you discover them?</i>				
_____				

Is there a family history of any of the following conditions?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Syphilis
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The National Safety Council states that 50% of children have a fall during the first year of their life (e.g. from a bed, changing table, stairs, etc.) Was this the case with you?  Mild?  N

Number of doses of antibiotics your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

Number of doses of prescription medications your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Please list all supplements/herbs/homeopathics/vitamins your child has taken in the last six months:

\_\_\_\_\_

\_\_\_\_\_

# Pregnancy/Delivery History

## Prenatal History

Patient Name: \_\_\_\_\_

Please describe the child's birth (at home, caesarean, hospital, adopted, etc.)

## Birth Interventions

- Forceps                       Emergency Caesarea                       Planned Caesarean                       Vacuum Extraction  
 Drug Induced Labor                       Other Emergency Procedures: \_\_\_\_\_

Number of ultrasounds during pregnancy: \_\_\_\_\_

How long was the delivery? \_\_\_\_\_ At how many weeks was the child born? \_\_\_\_\_ Number of siblings: \_\_\_\_\_

Name of Obstetrician/Midwife/Naturopath: \_\_\_\_\_ Age of mother at delivery: \_\_\_\_\_

Vaccinations or antibiotics by mother during pregnancy?  Y  N      Is patient's mother currently pregnant?  Y  N

Any major health problems with either birth parent?  Y  N      If yes, please explain: \_\_\_\_\_

Car Accidents: *Please explain in detail*

Traumas/Falls: *Please explain in detail*

Hospitalizations/Surgeries: *Please explain in detail*

Allergies: *Which ones and how did you discover them?*

Is there a family history of any of the following conditions?

- Cancer                       Tuberculosis                       Psoriasis                       Diabetes                       Syphilis

*The National Safety Council states that 50% of children have a fall during the first year of their life (e.g. from a bed, changing table, stairs, etc.) Was this the case with you?*  Mild?  N

Number of doses of antibiotics your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

Number of doses of prescription medications your child has taken:

During the past six months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Please list all supplements/herbs/homeopathics/vitamins your child has taken in the last six months:

# Notice of Patient Privacy

Dr. J Chris Chlebowski, Chiropractic Physician  
923 NE Couch Street  
Portland, OR 97232

## Notice of Patient Privacy (Short Form)

### Health Insurance Portability and Accountability Act (HIPAA)

J. Chris Chlebowski, D.C., is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Dr. J. Chris Chlebowski's duties with respect to your protected health information.

He may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask at the front desk and we will provide you with a copy.

We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information,

**I acknowledge comprehension and receipt of Notice of Privacy Policy.**

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Patient Informed Consent Form

Dr. J Chris Chlebowski, Chiropractic Physician  
923 NE Couch Street  
Portland, OR 97232

I, the undersigned, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapies (e.g. massage, ultrasound, interferential current), physiological therapeutics (e.g. mineral/vitamin supplementation, botanicals, homeopathic remedies, flower essences, etc.) on me (or the patient named above for whom I am the guardian) by Dr. J Chris Chlebowski.

I understand and am informed that though chiropractic treatments are usually beneficial and rarely cause a problem, like every other form of healthcare, there are some risks. These can include, but are not limited to, sprains, strains, fractures, disc injuries, strokes, dislocations, nutrient-drug interactions and nutrient-nutrient interactions.

I understand that the doctor will perform an exam in order to minimize any risks. However, I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interests. Finally I understand that Dr. Chlebowski gives no guarantee or assurance as to the results of his procedures.

I have read, or had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of present condition and for any further condition(s) for which I seek treatment.

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_