

# Pediatric 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.

# Pediatric Chief Complaint History

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

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

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

Is it getting worse?  Y  N What seemed to be the initial cause? \_\_\_\_\_

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

Name of physician and prior treatment(s): \_\_\_\_\_

Is your child in the care of physician for another condition?  Y  N

If yes, for what condition? \_\_\_\_\_

Has your child been hospitalized in the past ten years?  Y  N

If yes, for what condition? \_\_\_\_\_

Number of antibiotic doses your child has taken during the last six months? \_\_\_\_\_ Total doses during her/his lifetime? \_\_\_\_\_

Number of other prescription med doses your child has taken during the last six months? \_\_\_\_\_ Total during lifetime? \_\_\_\_\_

List medications: \_\_\_\_\_

Please list all supplements/herbs/homeopathics/vitamins is currently or has taken in the past year:

Please list all medications your child is currently taking:

Please describe your child's birth (eg. at home, caesarean, adopted, etc.)

## Birth Interventions

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Emergency Caesarean | <input type="checkbox"/> Planned Caesarean | <input type="checkbox"/> Vacuum Extraction          |
| <input type="checkbox"/> Drug Induced Labor  | <input type="checkbox"/> Forceps           | <input type="checkbox"/> Other Emergency Procedures |

At how many weeks was the child born? \_\_\_\_\_

## Please check if there was a history of:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Maternal Hypertension                                   | <input type="checkbox"/> Proteinuria          | <input type="checkbox"/> Recreational Drugs During Pregnancy |
| <input type="checkbox"/> Cigarette use during pregnancy                          | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Alcohol During Pregnancy            |
| <input type="checkbox"/> Medications During Pregnancy If yes, please list: _____ |   |  |

Child's Birth Weight: \_\_\_\_\_

Did your child come out head or feet first? \_\_\_\_\_

Which way was your child facing when delivered: Toward the front or back? \_\_\_\_\_

# Pediatric History (Continued)

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

What sports/activities is your child involved in? \_\_\_\_\_

To the best of your knowledge, list all of the vaccinations your child received and when.

Any reactions to the above vaccinations?  Y  N

If yes, please explain: \_\_\_\_\_

Was the child breast fed?  Y  N For how long? \_\_\_\_\_

## Family Health History

Information about your child's immediate family members (brothers, sisters, parents, and grandparents) is crucial to our understanding of your child's total health picture.

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

- Cancer       Tuberculosis       Diabetes       Depression  
 High Blood Pressure       Psoriasis       Syphilis

Relationship	Alive/Deceased	Age at Death	Present and Past Health Problems
Mother			
Father			
Sisters			
Brothers			
Grandparents			

Has your child ever:	If yes, please explain	Habit	None	Light	Mod	Heavy
Broken a bone? <input type="checkbox"/> Y <input type="checkbox"/> N		Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N		Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had strains or sprains? <input type="checkbox"/> Y <input type="checkbox"/> N		Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used a cane, crutch, or other support <input type="checkbox"/> Y <input type="checkbox"/> N		Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been struck unconscious? <input type="checkbox"/> Y <input type="checkbox"/> N		Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized, other than surgery? <input type="checkbox"/> Y <input type="checkbox"/> N		Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child have any drug allergies?  Y  N

Does your child have any food allergies?  Y  N

How were they discovered? \_\_\_\_\_

When was your child's last:	Never	0-6 mo	6-18 mo	Longer
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Pediatric Past Health History

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

Your doctors here at the clinic are interested in all aspects of your health. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional

F = Frequent

C = Constant

O F C	O F C	O F C	O F C
<b>Muscle / Joint</b>	<b>Genitourinary</b>	<b>Gastrointestinal</b>	<b>Respiratory</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed Wetting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder Infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating Abdomen	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Up Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Up Phlegm
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult Digestion	<b>Girls Only</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Betw Shoulders	<b>Eye, Ear, Nose &amp; Throat</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested Breasts
<b>General</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or Backache
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Circles Under Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heavy Menstrual Flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Over Stomach	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in Breast
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Menstruation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental Decay	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of Blood	Has your daughter started menses? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<b>Skin</b>	How old was she when she had her first period? _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Noise	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Glands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruises Easily	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Thyroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or Allergy	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far-Sightedness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Psoriasis	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night Terrors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin Eruptions/Rash	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	<b>Pain or Numbness in:</b>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms	
<b>Cardiovascular</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near-Sightedness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain Over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid Heartbeat		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Heartbeat		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Tailbone	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Murmur		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Posture	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	

# Pediatric Past Health History

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

Please check any of the conditions your child currently has or has had.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Exccema        | <input type="checkbox"/> Influenza          | <input type="checkbox"/> Polio            |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Edema          | <input type="checkbox"/> Lumbago            | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Malaria            | <input type="checkbox"/> Roseola          |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Measles            | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Cholera          | <input type="checkbox"/> Goiter         | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Herpes         | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Whooping Cough   |

# 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: \_\_\_\_\_