REPLENISH
CHIROPRACTIC

FILE #: _____

PERSONAL INFORMATION	
Full Name	Today's Date
Street Address	Date of Birth Age
City | State | Zip	Sex
Height ft. in.	Weight lbs. oz.
Mother's Full Name	Father's Full Name
Mother's Email	Father's Email
Mother's Cell Phone	Father's Cell Phone
Who is your child's primary care provider?	
How did you hear about Replenish Chiropractic?	

PRENATAL HISTORY

Were there any complications during pregnancy? Y / N
If yes, please explain:

Please list any medication(s) used during pregnancy:

Cigarettes or alcohol during pregnancy? Y / N If yes, please explain:
Was mother ill during pregnancy? Y / N If yes, please explain:
Any ultrasounds? Y / N If yes, please explain:
Did mother exercise? Y / N If yes, please explain:

Please explain any other notable concerns or remarks about your child's conception or pregnancy:

BIRTH HISTORY

Child's birth was: ▢ vaginal delivery ▢ planned cesarean ▢ emergency cesarean

Child's birth was at: ▢ home ▢ free-standing birth center ▢ hospital birth center ▢ hospital

Doctor/Obstetrician/Midwife Name(s):
At how many weeks was your child born?

Please check any complications or interventions:

▢ breech ▢ planned induction ▢ pain meds ▢ epidural ▢ episiotomy

▢ forceps ▢ unplanned induction ▢ vacuum extraction ▢ other: _____

Child's birth weight lbs. oz. Child's birth height in. APGAR Score:

CHILDHOOD GROWTH AND DEVELOPMENT

Is/was your child breastfed? Y / N
If yes, how long?
Any difficult breastfeeding?
Is/was formula ever used? Y / N
If yes, at what age?
If yes, what type?

Did/does your child suffer from constipation, colic, infantile reflux? Y / N
If yes, please explain:

Please explain any developmental delays or neurological issues you are concerned about:

Please list any food allergies or intolerances, including the date of onset:

How would you describe your child's diet? ▢ mostly whole, organic foods ▢ average diet ▢ many processed foods

Please describe any surgeries or hospitalizations for your child, including the year.

Has your child had any adverse reactions to vaccines? If yes, please explain.

Does your child have difficulty sleeping? Y / N
If yes, please describe:

Please explain any behavioral or social difficulties you are concerned about:

PRESENT COMPLAINT

What is your main reason for seeking care at Replenish Chiropractic?

When did this condition begin?
Was there an accident or injury involved?

Has your child had any past treatment for this condition? Y / N
If yes, please explain:

What makes the problem better?
What makes the problem worse?

List any drugs, supplements, or herbs that your child is taking:

What are you seeking from chiropractic care? ▢ resolve current condition ▢ overall wellness ▢ both

Has your child ever seen a chiropractor? Y / N
If yes, who and when?

How does this condition affect your child's daily life?

▢ Holding head up ▢ Tummy time ▢ Nursing ▢ Sitting up

▢ Standing along ▢ Walking ▢ Crawling ▢ Other: _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Headaches	___ Bed Wetting	___ Colic	___ Asthma	___ Fall from High Chair
___ Migraines	___ Dizziness	___ Reflux	___ Trouble Breathing	___ Fall from Table
___Backaches	___ Fainting	___ Stomach Aches	___ Rupture/Hernia	___ Fall from Crib
___ Neck Problems	___ Chronic Earaches	___ Poor Appetite	___ ADD/ADHD	___ Fall from Bed/Couch
___ Shoulder Pain	___ Ear Infections	___ Constipation	___ Behavioral Problems	___ Fall off Bicycle
___ Arm Problems	___ Seizures/Convulsions	___ Diarrhea	___ Muscle Pains	___ Fall off Swing
___ Leg Problems	___ Heart Trouble	___ Anemia	___ Growing Pains	___ Fall Down Stairs
___ Hip Pain	___ Sinus Trouble	___ Hypertension	___ Walking Trouble	___ Fall off Slide
___ Knee Pain	___ Orthopedic Problems	___ Skin Problems	___ Broken Bones	___ Fall off Monkey Bars
___ Foot Pain	___ Recurrent Colds/Flu	___ Sleep Problems	___ Scoliosis	___ Fall off Skateboard
___ Poor Posture	___ Digestive Disorders	___ Allergies	___ Joint Problems	___ Fall in Baby Walker

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprains/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.
Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deem necessary and chiropractic care, including spinal adjustments, as reported following my assessment.

_____ _____

GUARDIAN SIGNATURE DATE

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular day of operation. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate medical pathology. The doctor of Replenish Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention, so you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____

GUARDIAN SIGNATURE DATE

WRITTEN CONSENT FOR A MINOR - if this health profile is for a minor, please fill out and sign below.

Name of patient who is a minor/child: _____

I authorize Dr. Brit'ny Richardson and any and all Replenish Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Replenish Chiropractic.

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD _____ DATE _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

GUARDIAN SIGNATURE _____ DATE _____

IN OFFICE PHOTOS

We love to have photos in our office! If you allow us to have your photo in the office, please sign below.
For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Replenish Chiropractic, or anyone authorized by Replenish Chiropractic, of any and all photographs/videos which are taken of myself and my child, for the purpose of promotional TV, website, social media, and print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Replenish Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, regarding any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Replenish Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected according to Health Information and Privacy Act Laws.

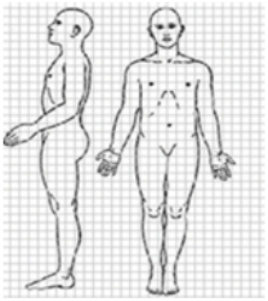
By my signature below, I authorize Replenish Chiropractic to take and use photos of me and my child according to the terms above.

GUARDIAN SIGNATURE _____ DATE _____

---------- OFFICE USE ONLY ----------

Cervical ROM	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	90° ☐
Extension	☐	☐	☐	☐	☐	70° ☐
L Lat Flex	☐	☐	☐	☐	☐	45° ☐
R Lat Flex	☐	☐	☐	☐	☐	45° ☐
L ROT	☐	☐	☐	☐	☐	90° ☐
R ROT	☐	☐	☐	☐	☐	90° ☐

Lumber ROM	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	90° ☐
Extension	☐	☐	☐	☐	☐	70° ☐
L Lat Flex	☐	☐	☐	☐	☐	45° ☐
R Lat Flex	☐	☐	☐	☐	☐	45° ☐
L ROT	☐	☐	☐	☐	☐	90° ☐
R ROT	☐	☐	☐	☐	☐	90° ☐



Posture		
Area	Findings	
F H P	+	-
Head Tilt	R	L
Head Rot.	R	L
↑ Shoulder	R	L
Thor. Tilt	R	L
Thor. Trans.	R	L
↑ Hip	R	L
Hip Rot.	R	L
Foot Flare	R	L