WISE CHIROPRACTIC

.

NEWBORN HISTORY

Birth to 2 Months

Today's Date: _____

Patient's Name: _____ **Sex:** M F **Date of Birth:** _____ **Age:** _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? _____ During day _____ At night _____

How was your baby delivered? (Vaginal or Cesarean) Were there any complications during delivery? _____

_____

If vaginal, were forceps or vacuum used during delivery? _____

Yes	No	
☐	☐	Does your baby go to sleep easily?
☐	☐	Does baby have a preferred sleeping position?
☐	☐	Does the baby cry if you change this sleeping position?
☐	☐	Does baby have any feeding difficulties?
☐	☐	Is baby being breast fed? If no, for how long was baby breast fed _____ weeks/mths
☐	☐	Does baby have a one sided breast feeding preference? Preferred breast: Left/Right
☐	☐	Is baby formula fed? Which formula or other milk source? _____
☐	☐	Does baby frequently spit-up after feeding?
☐	☐	Does your baby cry a lot? For how many hours each day? _____
☐	☐	Does baby pass a lot of intestinal gas?
☐	☐	Does baby have a preferred head position?
☐	☐	Does baby frequently arch his/her head and neck backwards?
☐	☐	Does baby cry or become irritable during a diaper change?
☐	☐	Has baby ever had a fever?
☐	☐	Has baby had any falls?
☐	☐	Has baby been in a car accident or near-miss?
☐	☐	Has baby had any other trauma?
☐	☐	Has your baby been vaccinated?
☐	☐	Do you have any other concerns you wish to discuss? _____

Patient's Legal Guardian Signature: _____ Date: _____

WISE CHIROPRACTIC

INFORMED CONSENT

I understand and I am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to: muscle strains, sprains, fractures, dislocation, intervertebral disc injury and cardiovascular accident. I understand that **Dr. Jonathan C. Wise** will not be able to anticipate all potential complications but will reply on clinical expertise and judgment to determine the correct course of treatment which will be in my best interest considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommendations evaluation and treatment procedures at any time.

I have read and understand the preceding statement and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative and exercise/rehabilitation therapies as deemed appropriate by Dr. Jonathan C. Wise. If at any time I have further questions or decide not to continue to consent in treatment, I understand I have the right and it is my duty to notify my doctor.

_____	_____	_____
Print Patient Name	Signature	Date

If patient is a minor:

_____	_____	_____
Print Parent/Guardian Name	Signature	Date

WISE CHIROPRACTIC

HEALTH INFORMATION PROTECTION PORTABILITY ACT (HIPPA)

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

In the course of your care as a patient at **WISE CHIROPRACTIC, INC.,** we may use or disclose personal and health related information about you in the following ways:

- Your personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (if they are responsible for the payment of your services).
- Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, newsletters and birthday correspondence to provide information about alternatives to your present care or for other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenue associated with your care. Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or regarding the status on your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preference.
You have the right to inspect and/or copy your health information for seven years or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice; we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health records in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclose by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rights.

If you have a concern regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our **OFFICE MANAGER**. If you would like further information about our policies and practices please contact our **OFFICE MANAGER**. This notice is effective as of ____/____/20__. This notice and any altercations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date