Lost Creek Chiropractic
3021Harding Highway Lima, Oh. 45804
Ph. (419) 221-2224 Fax (888)230-4551

Child Information

Date _____

Child's Name _____

Parent(s) Names

_____

Siblings' Names and Ages

_____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address

_____

Date of Birth _____m/_____d/_____y/ Gender: ○ Male ○ Female

Home Ph _____ Business Ph _____ Mobile Ph _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

○ Wellness ○ Prevention ○ Feel good ○ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:

_____

Name & Address of Primary Health Care Provider:

_____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

Any ultrasounds or other radiation? ◯ Yes ◯ No

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much?_____

Fall ill during pregnancy? ◯ Yes ◯ No please explain_____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOR

Was labor induced? ◯ Yes ◯ No

Duration of labor? _____

Duration of active (pushing stage) labor? _____

Did mother receive medications? ◯ Yes ◯ No

If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯Cesarean ◯Vacuum Extraction ◯Induction ◯Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No

Please explain:

_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising ◯ Odd shaped head

◯ Stuck in birth canal ◯ Fast or excessively long birth

◯ Respiratory depression ◯ Cord around neck

Was your child subjected to any of the following? Check all that apply:

◯ Silver nitrate drops in eyes ◯ Incubation How long? _____

◯ Vitamin K shot ◯ Separation from you How long? _____

◯ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No _____

Did your baby spit up after feeding? ◯ Yes ◯ No _____

Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No _____

Does child ever bang his/her head repeatedly? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? ◯ Yes ◯ No _____

If yes, hours per week? _____ Age child began? _____

Is school backpack used? ◯ Yes ◯ No Weight of backpack? _____kg/lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____

Does your child have trouble reading the board? ◯ Yes ◯ No _____

Does your child have difficulty with coordination? ◯ Yes ◯ No _____

CHEMICAL STRESS

Was/is child breast-fed? ◯ Yes ◯ No For how long?

_____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ◯ Yes ◯ No_____

Does your child have food allergies? ◯ Yes ◯ No_____

What is your child's favorite food? _____

What does your child regularly drink? _____

The type of diet your child usually follows is classified as: _____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs	_____	Fasting	_____	Fruit	_____
Fish	_____	Diet Food	_____	Organic Foods	_____

Coffee	_____	Beef	_____	Weight Control Diet	_____	Raw Vegetables	_____
Soft Drink	_____	Poultry	_____	Artificial Sweetener	_____	Whole Grains	_____
Fried Foods	_____	Seafood	_____	Cooked vegetables	_____		
Refined Sugar	_____	Dairy	_____	Canned/Frozen vegetable	_____		

Does your child have a bowel movement every day? ◯ Yes ◯ No _____

Does your child have regular or occasional skin rashes? ◯ Yes ◯ No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Un-consolable crying

◯ Irritability ◯ Arching of body

◯ Bowel disturbances ◯ Feeding disturbances

◯ Drowsiness ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many coursed of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? ◯ Yes ◯ No _____

Are there any smokers at home? ◯ Yes ◯ No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Behavior problems? ◯ Yes ◯ No

_____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend day care? ◯ Yes ◯ No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: _____

At what age did your child:

Respond to sound?	_____	Sit alone?	_____
Follow an object?	_____	Teethe?	_____
Hold head up?	_____	Crawl?	_____
Vocalize?	_____	Walk?	_____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

_____

On father's side:

_____

Does sibling's have any health concerns? ◯ Yes ◯ No

If yes, please describe: _____

Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of

(PARENT/GUARDIAN NAME)

_____ have read and fully understand the terms

(CHILD'S NAME)

of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

Lost Creek Chiropractic

Our policy for billing insurance

1) We are happy to bill your insurance for you.
2) We will call your insurance company to verify your chiropractic benefits.
3) Your insurance may not pick up all services rendered, or may pay differently than they said. So you will be responsible for the remaining amount.
4) Payment is expected in full for the first visit. Once we verify your benefits. We can adjust your balance accordingly.
5) Please sign below that you have read and agree with these terms.

_____ _____

Client name Date

If there are any questions please ask, we are happy to clarify this policy

Anthony Rump DC, LLC
3021 Harding Hwy Lima Ohio 45804
419.224.2221
www.docrump.com

Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic/Quantum Neurologist (QN) doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic/QN tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. Dr Rump is a chiropractic doctor and Quantum Neurologist that provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Dr Anthony Rump DC QN, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic/QN treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Others: _____

No One_____
May we leave messages regarding your personal healthcare information on any answering device/email/texting?
i.e. home answering machines or cell phones? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____