

Tim Yoder, D.C.  
Back To Health Chiropractic & Massage Therapy @ Fisher's Landing  
16111 SE McGillivray Blvd. Ste A  
Vancouver, WA 98683 (360) 254-0994

## PEDIATRIC WELCOME

Health is a journey not a destination. This is the first step!

### 1. About Child

Child's Name: \_\_\_\_\_

Child's Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Child's Gender:  Male  Female

Birth Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Birth Height: \_\_\_\_\_ Current Height: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

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

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

Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Work Phone: (\_\_\_\_) \_\_\_\_\_

Father's Work Phone: (\_\_\_\_) \_\_\_\_\_

### 2. Birth Information

Type of Birth:

Normal Vaginal  Cesarean

Forceps  Home

Breech  Hospital

Birthing Center

Problems During Pregnancy: \_\_\_\_\_

\_\_\_\_\_

Problems During Labor/Delivery: \_\_\_\_\_

\_\_\_\_\_

APGAR Scores: \_\_\_\_\_

Was there presence at birth of:

Jaundice (Yellow)

Cyanosis (Blue)

Congenital anomalies/defects: \_\_\_\_\_

### 3. Infant Information

Infant feeding:  Breast  Bottle  Formula

Obstetrician/ Midwife: \_\_\_\_\_

Location: \_\_\_\_\_

Pediatrician/ Family Doctor: \_\_\_\_\_

Location: \_\_\_\_\_

Date of Last Visit to MD: \_\_\_\_\_

Purpose of last visit: \_\_\_\_\_

Has your child been treated on an emergency basis?

Yes  No

If Yes, Why? \_\_\_\_\_

\_\_\_\_\_

### AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this clinic and its doctor(s) to administer care, as they deem necessary to my son/daughter/ward.

Signed: \_\_\_\_\_

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

Witnessed: \_\_\_\_\_

Chiropractic Assistant

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services performed. X-rays remain the property of this clinic.

Signed: \_\_\_\_\_

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

**PREGNACY HISTORY:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DELIVERY/ BIRTH HISTORY:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

- At what age did the child:  
 Respond to sound \_\_\_\_\_  
 Follow an Object with Eyes \_\_\_\_\_  
 Hold Head Up \_\_\_\_\_  
 Sit Alone \_\_\_\_\_  
 Crawl \_\_\_\_\_  
 Stand \_\_\_\_\_  
 Walk Alone \_\_\_\_\_

**CHILDHOOD DISEASE:**

- Yes  No Chicken Pocks  
 Yes  No Mumps  
 Yes  No Measles  
 Yes  No Rubella  
 Yes  No Rubella  
 Yes  No Whooping Cough

OTHER: \_\_\_\_\_  
 \_\_\_\_\_

Surgeries:  Yes  No

Medications: \_\_\_\_\_  
 \_\_\_\_\_

Accidents: \_\_\_\_\_  
 \_\_\_\_\_

Family History: \_\_\_\_\_  
 \_\_\_\_\_

**HAS THIS CHILD EVER SUFFERED FROM:**

- Yes  No Allergies  
 Yes  No Anemia  
 Yes  No Arm problems  
 Yes  No Artificial Bones/ Joints  
 Yes  No Arthritis  
 Yes  No Asthma  
 Yes  No Backaches  
 Yes  No Bed Wetting  
 Yes  No Behavioral Problems  
 Yes  No Broken Bones  
 Yes  No Cancer  
 Yes  No Chronic Earaches  
 Yes  No Colds/ Flu  
 Yes  No Constipation  
 Yes  No Convulsions  
 Yes  No Diabetes  
 Yes  No Diarrhea  
 Yes  No Dizziness  
 Yes  No Fainting  
 Yes  No "Growing Pains"  
 Yes  No Headaches  
 Yes  No Heart Trouble  
 Yes  No Hyperactivity  
 Yes  No Hypertension  
 Yes  No Joint Problems  
 Yes  No Leg Problems  
 Yes  No Muscle problems  
 Yes  No Neck pressure  
 Yes  No Neuritis  
 Yes  No Orthopedic Problems  
 Yes  No Paralysis  
 Yes  No Poor Appetite  
 Yes  No Rheumatic fever  
 Yes  No Ruptures/ Hernias  
 Yes  No Sinus Trouble  
 Yes  No Tuberculosis  
 Yes  No Walking Problems

Present History: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Tim Yoder, D.C.  
Back To Health Chiropractic & Massage Therapy @ Fisher's Landing  
16111 SE McGilivray Blvd. Ste A  
Vancouver, WA 98683 (360) 254-0994

## Parental Consent for Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care. It is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. It will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal, physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral subluxations:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate interference to the expressions of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statement.  
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Tim Yoder, D.C.  
Back To Health Chiropractic & Massage Therapy @ Fisher's Landing  
16111 SE McGillivray Blvd. Ste A  
Vancouver, WA 98683 (360) 254-0994

## Acknowledgement of Protected Health Information Regulations

I, \_\_\_\_\_, consent to the release of protected health information that is required to carry out treatment and payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- ◆ I have the right to place restrictions on the way my protected health information is used or disclosed.
- ◆ I understand that Back to Health Chiropractic Clinic is not required to agree with my request restrictions. I also understand that once Back to Health Chiropractic Clinic agrees to my restrictions, it must comply with those restrictions.
- ◆ I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- ◆ I understand that Back to Health Chiropractic Clinic must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- ◆ Back to Health Chiropractic Clinic has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you by providing you with a new notice.

Individual:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date