Virtue Chiropractic

New Patient Initial Interview - Pediatric

Welcome to Virtue Chiropractic. Your time here today is very important. The information you fill in here is paramount to Dr. Loren reaching conclusions and directional decisions about your child's health, from the past to the present and into the future. If there is anything you're not sure of then please don't hesitate to ask one of our friendly team members.

About the Child:

Last Name: _____ First: _____ Preferred Name: _____

Gender: Male Female Date of Birth: _____ Age: _____

Number of Siblings: _____ Sibling(s) Names & Ages _____

Social Security Number (for insurance purposes) :_____

About the Parent/Guardian:

Name: _____ Birthdate: _____ Age: _____

Mailing Address: _____City_____ Zip Code_____

Occupation_____Employer_____

Email: _____

Spouse's Name: _____

Phone: H: _____ Cell: _____

Cell Phone Provider (for reminders): _____

Who can we thank for referring you OR How did you hear about us? _____

Reason for the visit:

Describe the reason for the visit (Please be specific):

_____

_____

When did this start? _____

Has the condition been: Staying the Same Getting Worse Getting Better

Have you see other providers for this condition? _____

_____

What is this affecting that is MOST important in your child's life? _____

_____

What health goals, if your child were to complete or accomplish it, would have the greatest impact on his/her life? _____

_____

Major injuries/surgeries/hospitalizations: _____

_____

Child's Health History:

Please circle all that apply or have applied to your child: (place a **C** for current and **P** for past)

ADD/ADHD	Allergies/Sinus Troubles	Anxiety	Asthma/Chronic Bronchitis	Autism/Asperger's
Back/Neck Pain/Stiffness	Bed Wetting	Breathing Problems	Colic/Acid Reflux	Constipation
Depression	Detachment/Distant	Diabetes	Diarrhea	Difficulty Gaining Weight
Digestive Problems	Ear or Other Infections/Tubes	Extreme Opposition/Defiance/ Anger	Fatigue	Food Sensitivities
Frequent Sickness	Headaches	Irritability/Nervousness	Learning Disorders	Nausea/Vomiting
Non-Verbal	OCD	Overweight	Sleep Issues	Vision Problems

Other:_____

Is there anything else regarding your child's condition you feel the doctor should know? _____

_____

Medications:

Anxiety/Depression	ADD/ADHD	Asthma	Antibiotics	Pain Narcotics
Migraine/Headache	Acid Reflux	Digestive	Other	

Other: _____

Name of Medications: _____

Vitamins:

Multi-Vitamin	Fish Oil/Omega-3	Vitamin D3	Probiotics	Other

Other: _____

Diet:

GAPS	Specific Carb Diet	Gluten Free	Dairy Free	No Special Diet

Other: _____

Mother's Pregnancy and Labor:

During the pregnancy, did you use: Drugs Tobacco Medications Alcohol
If yes, please describe: _____

Location of Birth: [ ] Hospital [ ] Birthing Center [ ] Home
Birth Interventions: [ ] Forceps [ ] Vacuum Extraction [ ] Cesarean Section
[ ] Pitocin/Induced [ ] Epidural [ ] Premature Birth
[ ] Anesthesia [ ] Excessive Force [ ] Special Meds/Procedures
Describe anything above/additional complications, experiences: _____
_____

Position of the Baby: [ ] Vertex [ ] Breech [ ] Brow/Face [ ] Transverse
Birth Weight: _____ Birth Height: _____ APGAR Score: _____

Yes **No** Did you experience any illness when pregnant? _____
Yes **No** Did you have ultrasounds performed? How many? _____
Yes **No** Did you choose to vaccinate your child? _____
Yes **No** Did you nurse the baby? How long? _____
Yes **No** Was the formula fed? _____
At what age were solids introduced? _____

Did/Does the mother have any of the following:

Autoimmune Issues	Chronic Fatigue	Thyroid Dysfunction	Hormonal Imbalances	

Lifestyle Habits

Does your child exercise daily? _____
Does your child drink soda? How much/often? _____
Does your child have a positive self-esteem or self-image? _____
How many hours does your child spend on screens/day (TV, tablet, computer, phone)? _____
Does your child experience prolonged sadness? _____

Child's Health History

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs).
Was this the case with your child? **Yes** **No**
Is/Has your child been involved in any sports? Please list: _____
_____
Has your child ever been involved in a car accident? **Yes** **No** List: _____
Does your child have difficulty interacting with others **Yes** **No** List: _____
Have you ever noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?
Yes **No** List: _____
Stress level at school (1-10) 10 being highest: _____
Personal stress level (1-10) 10 being highest: _____
Other physical traumas not described above? _____
Has your child suffered any emotional traumas? _____

Childhood Diseases:

Chicken Pox:	**Yes**	**No**	Age: ____	Mumps:	**Yes**	**No**	Age: ____
Whooping Cough:	**Yes**	**No**	Age: ____	Rubella:	**Yes**	**No**	Age: ____
Rubeola:	**Yes**	**No**	Age: ____	Other: _____			

Please list your other providers below (this will not be used to discuss your child unless you specify it in the 'HIPPA' section.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

Check all that apply to your child

MORO REFLEX

This reflex is an automatic reaction to sudden changes in sensory stimuli. Sudden bright light, loud noise, touch, and change in body position can trigger this reflex.

The MORO reflex creates instant arousal of the baby's survival systems, in essence, the baby responds as if reacting to a threat. The Moro reflex trains the baby's nervous system in developing the "fight or flight" survival response. It is also the baby's instinctual response to summon a caregiver.

When the MORO gets activated these physiological responses occur: Release of stress hormones adrenaline and Cortisol, Increased breathing rate, shallow breathing, and Increased heart rate and blood pressure.

An unintegrated Moro Reflex is often accompanied by hypersensitivity to incoming stimulus and health challenges such as allergies and asthma.

Ideally the Moro emerges in the womb 9-12 weeks gestation and is integrated by 4 months of age. Moro integration is complete when the baby learns more mature startle reflexes, sometimes called the Strauss Reflex.

Common long term symptoms that present from the MORO Reflex:

( )sleep disturbances
( )easily triggered anger or emotional outbursts
( )shyness
( )poor balance and coordination
( )poor stamina
( )poor digestion
( ) weak immune system
( )motion sickness
( )hypersensitivity to light, movement, sound, touch and smell
( )difficulties with vision, reading and writing
( )difficulties adapting to change
( )cycles of hyperactivity followed by extreme fatigue
( )easily distracted, difficulties filtering out outside stimuli
( )difficulties catching a ball
( )difficulty with visual perception

( )easily fatigued, irritable under fluorescent lighting

Tonic Labyrinthine Reflex

The tonic labyrinthine is broken up into two parts, the forward TLR and the Backwards TLR. The Forward TLR is present as the head bends forward, the whole body, arms, legs and torso curl forward in the characteristic fetal position. In the backwards TLR, as the head is bent backwards, the whole body, arms, legs and torso straighten and extend.

The TLR helps the baby to adapt to gravity and learn neck and head control! This reflex gives the baby and opportunity to practice balance, increase muscle tone, and develop the proprioceptive and vestibular sense. Eventually the TLR interacts with other reflexes and body processes to help develop coordination, posture and correct head alignment. Head alignment with the rest of the body is necessary for balance, visual tracking, auditory processing and muscle organization. All of which are vital to the ability to focus, pay attention and learn.

Common symptoms if reflex is retained:

( )Balance and Coordination issues
( )Shrunken posture
( )easily fatigue
( )muscle tone to weak or too tight
( )difficulty judging distance, depth, space and speed
( )"W" leg position when sitting
( )Motion Sickness
( )Visual, speech, and auditory difficulties
( )Tendency to be cross eyed
( )Toe walking

ASYMETRICAL TONIC NECK REFLEX

They Asymmetrical Tonic Neck Reflex is the most common reflex found in our office, and creates some of the largest symptoms when not developed well. This is a reflex that happens when the infant turns their head, what happens is the infants arms and legs on the side they turned the head toward automatically straighten! The ATNR provides stimulation for development of muscle tone and the vestibular system. The ATNR also helps to develop hand eye coordination. By 6 months of age this reflex should be developed and evolve into more complex movements. It should be inhibited prior to crawling and if not developed well creates abnormalities in crawling. It is also the most significant cause of inability to function well in school!

Common Symptoms that patient present with:

( )Dyslexia
( )Reading, listening, handwriting and spelling difficulties
( )poor sense of direction
( )Confused handedness
( )Focus and Balance Difficulties

SYMMETRICAL TONIC NECK REFLEX

The STNR is a reflex that helps to develop neck control and low back control so a baby can lift their head and focus far distance. The STNR also prepares the baby for creeping and crawling. The STNR is a reflex that links head movements to arm and leg movements, so when still present it allows the baby to move their head and create automatic movements of the upper and lower extremities. This is important because it allows us to build muscle that is vital for later movements like crawling and walking! This is another reflex that if still present will create problems in school! This is because up-and-down head movement causes the arms and legs to reflexively move. This distracts attention always from concentration and learning more difficult!

Common symptoms when reflex is present:

( )Squirming and fidgeting: poor posture, slouching
( )Headaches from muscle tension

( )Difficulties writing and reading
( )Apelike walking
( )Vision disorders
( )Trouble Staying on task
( )Clumsy and messy eating

SPINAL GALANT REFLEX

The Spinal Galant reflex is a rotation of the hips when the back is stroked along the spine in the low back. It is thought to help infants balance and coordinate the body for belly-crawling and creeping. It is likely connected to bladder function, because a high percentage of children who are bedwetting past age 5 have an active Spinal Galant reflex.

Common symptoms:

( )Bedwetting
( )hip rotation to one side
( )poor posture
( )Difficulties sitting still
( )Scoliosis
( )Fatigue
( )Poor concentration
( )Poor Short Term memory
( )Irritable bowel syndrome

ORAL, HAND, AND FOOT REFLEXES

Some of the Oral, Hand and Foot reflexes are linked at infancy. We often see babies kneading their hands while they suckle. When these reflexes stay active, we may see adults move their mouths or tongues while writing. Many Foot reflexes will can interfere with walking and can result in toe walking to compensate

Common symptoms:

( )Speech delays or difficulties
( )Difficulties in social situations
( )Manual dexterity issues
( )Handwriting difficulties
( )Loose, easily sprained ankles
( )Flatfooted or walking on side of feet
( )Difficulties expressing written ideas
( )Swallowing difficulties
( )Drooling
( )Poor pencil grip
( )TMJ issues
( )Toe walking
( )Hip rotation

Please use this space and the space on the back to write down any other useful information for Dr. Loren so he can best serve your child. The more information, the better. Please let us know if there is anything that makes your child feel uncomfortable and if there is anything that helps your child feel more comfortable.

CONSENT TO TREAT A MINOR CHILD

I authorize Dr. Loren Liming to administer care as they deem necessary to my _____. (Relationship to minor)

Are there any other guardians or adults that will be at appointments? Y/N
If yes, are they allowed to receive information regarding the minor? Y/N
Please list the name(s) of any other individual(s) and relationship to the minor:

Name:_____ Relationship to Minor:_____
Name:_____ Relationship to Minor:_____
Name:_____ Relationship to Minor:_____
Name:_____ Relationship to Minor:_____

Medical Information (HIPAA) Release Form

Name: _____ **Date of Birth:** ____ / ____ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis; records; examination rendered to me; and claims, billing, and account information. This information may be released to:

[ ] Parent/Guardian _____

[ ] Siblings _____

[ ] Attorney _____

[ ] Other Health Providers_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

PATIENT NAME (PLEASE PRINT):_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:** _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities.

Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

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

The following office procedures allow Virtue Chiropractic to operate in an efficient manner and allow us to support our practice members with their care. By signing below you are giving us authorization to follow through with these procedures. **Should you desire something *not* to be done, place a line through anything you refuse and initial.**

- We many need to contact you by telephone or text at home or at work regarding appointments and other matters related to care/appointments in this office.
- We may need to leave a message with another person (spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We acknowledge and thank everyone who refers friends or family members to our office. We would like to directly thank the person who referred you and use your name.

We often take video of patients as they start care and throughout their care in our office. This is used to make a progress video, which helps Dr. Loren and see the progress.

We also sometimes share the videos to give hope to other families dealing with similar situations. Please initial if you consent Virtue Chiropractic to take video of you and/or your child and utilize it on social media, newsletters, our websites and throughout the office. _____

You have the right to refuse any of this authorization without affecting your care or the relationship with anyone at Virtue Chiropractic. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

I have read and understand your Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:** _____

Informed Consent Form

Chiropractic care is recognized as being an effective and safe method of care for many areas of life.

However, as in all health care, there are some very slight risks with chiropractic care.
This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [1];
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments) [2] [3].

*Put in context, chiropractic has been shown to be **250 times safer** than anti-inflammatory drugs [4] and safer than driving a car [5].*

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding [6] [7]. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates *unexpected improvement* in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health.[8] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14%: eyes/vision.

Broken down into subcategories the benefits were reported as follows:

- Easier to breathe: 21%,
- Improved digestive function: 20%,
- Clearer/better/sharper vision: 11%,
- Better circulation: 7%
- Changes in heart rhythm/blood pressure: 5%,
- Less ringing in the ears/improved hearing: 4%

(The reference for the information quoted above are available upon request.)

Agreement:

I have read and understood the information above. I do not expect Dr. Loren LIming to be able to anticipate or explain all the risks and complications. I wish to rely on Dr. Loren Liming to exercise their judgment during the course of care which they feel at the time, based upon the facts known, is in my best interests. I have, to the best of my knowledge, provided Dr. Loren Liming with a complete and accurate health history. I have had the opportunity to discuss with Dr. Loren Liming the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation at Virtue Chiropractic. I hereby request and consent to chiropractic adjustments, therapy and other chiropractic suggestions wherever Dr. Loren Liming determines necessary. By signing below, I agree to care at Virtue Chiropractic.

Print name: _____ **Signature:** _____ **Date:** _____

(Parent /guardian if under 18 years)

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8):530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9):42-47.
(6) Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15;22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999;22:559-64.

Financial Policy

I understand that payment of services is due at the time service is given, unless further discussed with Virtue Chiropractic.

Insurance

I understand that my insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for care might not be covered by my contracted benefits. I am liable for all charges that my insurance plan does not cover. I have been notified that insurance may not cover all the services provided for care. If payment is denied for these serves, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductive is due at the time of service. I understand that health and accident insurance policies are an arrangement between an insurance company and myself. I understand that Virtue Chiropractic will prepare and submit the claims if necessary to the insurance company and that any amount authorized to be paid directly to Virtue Chiropractic will be credited to my account upon receipt. However, I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I have read, understood and agree upon the terms stated in the Financial Policy.

PATIENT NAME (PLEASE PRINT):_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:** _____