HEALTHPRO
CHIROPRACTIC | ACUPUNCTURE

9720 Cypresswood Drive, Suite 130
Houston, TX 77070
P: 281.809.0100
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HealthPro Pediatric New Patient Forms Age Infant - School Aged

Childs Name: _____ **Parents Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____**Email:** _____

Date of Birth: _____ **Age:** _____ **Sex:** (check) ☐ Male ☐ Female

Number of Siblings_____ **Birth Weight** _____ **Birth Length** _____ **Current weight and length** _____

How did you hear about our office: _____

Has your child ever been to a chiropractor before: ☐ Yes ☐ No What for? _____**Have you**? ☐Yes ☐No

Midwife/Obstetrician: _____ **Family MD/Pediatrician**_____

Date of Last visit: _____ **Purpose**:_____

Immunization History: ☐ No Vaccines ☐ Delayed Schedule ☐ On Schedule **Adverse reactions**:_____

Number of doses of Antibiotic taken: During last 6 months:_____ During lifetime:_____

Medications taken and for what: _____

Vitamins taken: _____

Surgeries / Hospitalizations:_____

Third Trimester Presentation: ☐ Vertex (head down) ☐Breech (head up feet down / head and feet up) ☐Transverse (across lie) ☐Face/Brow (face anterior facing pubic bone / baby spine to mom spine)

Type of Birth: ☐ Natural/ Vaginal Unmedicated ☐ Vaginal Medicated ☐Forceps ☐ Vacuum ☐ Cesarean

☐ Induction (reason):_____ **Did you receive fertility treatment to conceive**:_____

Birthing Location: ☐ Home ☐ Birthing Center ☐ Hospital

Medications During Pregnancy/Labor/Delivery: _____

Problems During Labor/ Delivery _____

Gestational Weeks at Birth _____ **Hours in Labor** _____ **Time Pushing** _____

Congenital Anomalies / Defects? (explain)_____

Delivery/Birth History: _____

Infant Feeding: ☐ Breast ☐ Formula (which one?)_____ **Issues with feeing**: _____

Number of Hours Sleeping per Night _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor_____

Location of Sleep & Naps ☐ Crib/ Bassinet ☐Family Bed ☐ Rock and Play ☐ Car Seat ☐ Swing _____

What signals has your child's body been communicating?

☐ Asthma	☐ Frequent Diarrhea	☐ Failure to Thrive / Slow Weight Gain
☐ Respiratory Tract Infections	☐ Constipation	☐ Slow or Absent Reflexes
☐ Sinus Problems	☐ Flatulence	☐ Asymmetrical Crawling or Gait
☐ Ear Infections	☐ Headaches/Migraines	☐ Weight Challenges
☐ Tonsillitis	☐ Neck Pain	☐ Bed Wetting
☐ Strep Throat	☐ Torticollis / Head Tilt	☐ Sleep Problems
☐ Frequent Colds / Croup	☐ Trouble Feeding on One Side	☐ Night Terrors
☐ Recurrent Fevers	☐ Back Pain	☐ Tip Toe Walking
☐ Eczema	☐ Growing Pains	☐ Sensory Processing Issues
☐ Rashes	☐ Scoliosis	☐ Seizures
☐ Allergies	☐ Red, Swollen, Painful Joint	☐ Tremors / Shaking
☐ Food Sensitivities	☐ Colic	☐ ADD / ADHD
☐ Digestive Problems	☐ Frequent Crying Spells	☐ Autism / PPD
☐Tongue/lip/cheek tie	☐ Plagiocephaly/flat head	☐ Trouble latching / breastfeeding

Spinal Traumas: ☐ Falls ☐ Motor vehicle accidents ☐ Sports Injuries _____ ☐ Other _____

Do you have a specific concern that brings you in?

☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.

☐ Yes: _____

What is your primary goal for your child at our clinic? _____
_____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference, called subluxations. You've taken an important step for your child's future

Consent to Evaluation and Treatment of a Minor Child

I _____ (print name) being parent or legal guardian of _____(print name of minor) hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

Consent To Treatments

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment, acupuncture treatment or massage therapy performed by the doctors of HealthPro Chiropractic and Acupuncture and anyone working in the clinic authorized by the above referenced doctors of chiropractic. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by HealthPro Chiropractic and Acupuncture doctors of chiropractic or staff.

_____INTIAL I understand that there are risks associated with any treatment. Chiropractic and acupuncture are very low risk procures. Potential risks include slight pain, discomfort or soreness in the area treated. Associated risk factors for acupuncture include but are not limited to the following: bruising, blistering, bleeding, redness around the site where the needle was inserted, weakness, fainting, nausea, temporary discoloration of the skin, possible aggravation of the symptoms existing prior to treatment, skin infection or broken needle.

_____ _____

Consenting Adult Signature Date

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AGREEMENT AND INSTRUCTION FOR DIRECT PAYMENT BY PRIVATE AND GROUP OR ACCIDENT AND HEALTH INSURANCE

RE: Patient: _____ Insured: _____

Employer: _____

Group / Claim #: _____

S.S. or ID#: _____

I hereby instruct and direct the _____
Insurance Company or Law Office to pay by check made out and mailed directly to:

HealthPro Chiropractic and Acupuncture
9720 Cypresswood Drive, Ste 130
Houston, TX 77070

Or, if my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

HealthPro Chiropractic and Acupuncture
9720 Cypresswood Drive, Ste 130
Houston, TX 77070

The medical expenses benefits allowable under my health or PIP policy, and otherwise payable to me under my current insurance policy as payment toward the total charges for chiropractic services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance for chiropractic service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to you as the insurance company or attorney.

Dated this _____ day of _____, 20____

Policyholder _____

Patient Signature _____

Witness _____

***** Please note most insurance companies will not cover pediatric chiropractic services. HealthPro does offer affordable cash prices.***

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Patient Provider Email Agreement

Name:
Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has the advantages over office visits or telephone calls. But remember, there are also important differences. Email is not the same as calling our office, there is no person at the other end of the call – just a computer. You can't tell for certain when your messages will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication that email affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via email.

- Email is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- Email is great for asking those little questions that don't require a lot of discussion. Appropriate uses of email also include referral letters, excuse notes needed for work/school after an appointment, and billing/insurance questions.
- Emails should not be used to communicate sensitive information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Email is not confidential. It is like sending a postcard through the mail. Our staff may read your emails to handle routine, non-emergency matters. You should also know that if sending emails from work, your employer has a legal right to read your email if he or she chooses.
- Email may become a part of the medical record when we use it, a copy may be printed and put in your chart.
- Email is not a substitute to seeing a doctor at HealthPro. If you think that you may need to be seen, please call and schedule an appointment.
- Emails may be forwarded to our staff for handling, if appropriate.

Finally, HealthPro reserves the right to revoke permission of the email system at any time.

☐ **I DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security of information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state of which my doctor is licensed.

PATIENT:
Patient Name: _____

Patient Signature: _____

E-Mail Address: _____

Date: _____

TESTIMONIAL RELEASE

NAME: _____

I hereby grant permission for my picture or video(s) to be used by *HealthPro Chiropractic & Acupuncture* for educational purposes of the practice, on the website or via social media and internet forums. I understand that this agreement releases *Dr. Alayna Pagnani-Gendron & Dr. Daniel Dannug with HealthPro Chiropractic & Acupuncture* and the producer of his/her/their educational materials from any legal responsibilities arising from the use of said pictures or video(s) in the aforementioned capacity.

Signature:_____

Printed Name:_____

Date: _____

Witness:_____