

RAYA CLINIC

200 Queen Street ♦ Southington, CT 06489 ♦ 860-621-2225

CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Full Name _____ Date _____

Mailing Address _____
Street City State Zip

Guardian Name _____ Work Phone () _____

Mobile Phone () _____ E-Mail address _____

Social Security # _____ Birth Date _____

Emergency Contact Phone other than parents: _____

Authorization for care of a minor

I hereby authorize The Advanced Back Center, P.C., Dr. Stacey Raya and whomever they designate to administer care as they deem necessary to my son/daughter.

Name of legal Guardian (printed) : _____ Witnessed : _____

Legal Guardian Signature: _____ Date: _____ Witness Signature: _____

Name of person responsible for account _____

Assignment (if applicable) and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Advanced Back Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for obtaining a referral if necessary. I authorize the release of my X-rays and medical records from any provider, hospital, attorney or insurance company.

Responsible Party Signature _____ Relationship (Self/parent/spouse) _____ Date _____

I. Primary Complaint: _____

Location of primary complaint: _____

Pain Scale: 0 (No Pain) _____ 10 (Worst Pain) _____

Current Pain
At its Worst
At its Best

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

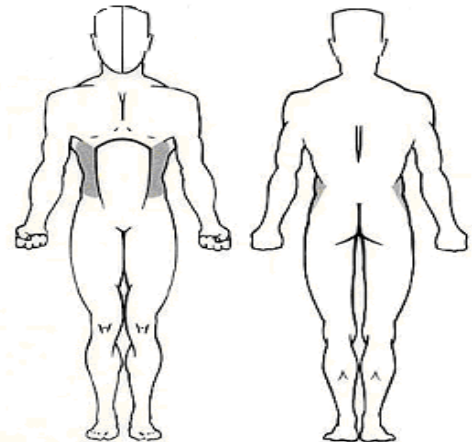
Does the pain radiate anywhere? _____

Have you had a MRI, X-ray, CTscan on this area? Yes/No Where? _____

Does it hurt more in Morning /Afternoon/ Night/All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: () _____



Please Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness ooo Pins and Needles ... Burning xxx Stabbing ///
Other +++

Secondary Complaint: _____

Location of primary complaint: _____

Pain Scale: 0 (No Pain) _____ 10 (Worst Pain) _____
Current Pain _____
At its Worst _____
At its Best _____

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

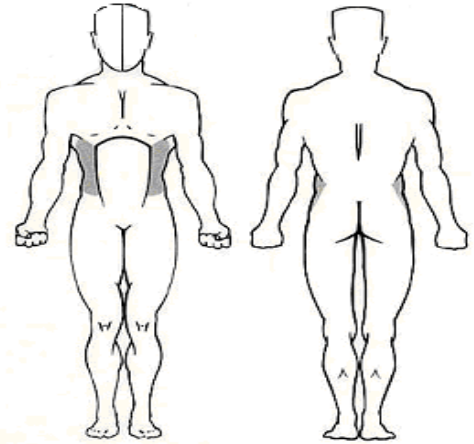
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Does it hurt more in Morning/ Afternoon/ Night/ All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: (____) _____



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Developmental History

Was the infant alert and responsive within 12 hours of delivery? Yes/No

If "No", explain: _____

At what age did the child: (if not applicable the just put N/A)

Respond to sound: _____ Following an object with his/her eyes: _____

Hold head up: _____ Sit alone: _____

Crawl: _____ Walk Alone: _____

Stand: _____

Social Behavior

Seems normal for age: Yes/No If "No", explain: _____

Childhood Disease/Immunization History

Yes No Chicken Pox Age: _____

Yes No Mumps Age: _____

Yes No Rubella (german measles) Age: _____

Yes No Rubeola Age: _____

Yes No Whooping cough Age: _____

Other Immunization/Childhood diseases (Name and age): _____

List of Medications you are currently on: _____

Have they been in an auto accident? Yes/No € Past year € Past 5 years € Over 5 years €
Never

Describe _____

Have you had any other personal injury or accident? € Past year € Past 5 years € Over 5 years

Do you currently have an open workman's compensation or personal injury case? Yes / No

If you have an open case, please tell us your attorney's name :

HEALTH HISTORY:

Mark the following conditions you may have had or have now (“-“ have had, “+” have now)

- | | | | | | |
|--|---------------------------------------|---------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Polio | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Other: (Please Explain) _____ | | | | | |

SERVICES

Please check all the services you wish to receive or may be interested in:

Chiropractic:

- Adjustments
- Physical Therapy
- Exercises

Acupuncture:

- Emotional Issues
- Addictions
- Fatigue
- Chronic Pain
- Insomnia/Sleeping Disorders
- Stop Smoking
- Appetite Control

Nutrition:

- Saliva Test (Hormone Levels)
- Contact Reflex Analysis (Nutritional Analysis)
- Vitamins/Supplements
- Allergy Food Testing
- Hair Test (Screen for toxic metals and minerals)
- Detoxification of Liver and Intestines

Family History: Some health conditions are the result of hereditary weakness. Information about immediate family members, brothers, sisters, parents, grandparents will give us a better understanding of your total health picture.

Relationship

Present and Past Health Problems

Prenatal History

Duration of Gestation: ____ Weeks Pregnancy without complications? Yes/No

If "Yes", please explain: _____

Type of Birth: Normal Forceps Breech Cesarean

Place of Birth: Home Birthing Center Hospital

List any medications taken during the delivery:

List any complications of delivery: _____

Apgar Score at Birth: _____

Weight at Birth: _____

Apgar Score at 5 minutes: _____

Length at Birth: _____

Was there presence at birth: Jaundice(yellow YES/NO

Cyanosis(Blue) YES/NO

Congenital anomalies/defects:

Nutritional History

Infant Feeding: Breast YES/NO Bottle YES/NO Formula YES/NO

Number of hours of sleep per night: _____ Quality of Sleep: Good/Fair/Poor

If breastfed, how long? ____ months. Formula began at age ____ for ____ months Type: _____

Cow's Milk began: age ____ Began Solid Foods at age ____ months

Were Commercially prepared baby foods used? Yes/No Type: _____

Food/Juice Intolerance? Yes/No Type: _____

Informed Consent For Care

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

Prior to receiving care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedure are will assist us in determinaing if chiropractic care, spinal decompression, nutritional consultation and/or acupuncture are needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I have read, or had read to me, the informed consent. I have also had an opportunity to ask questions about the content, and by signing below, I agree to chiropractic care. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

I understand and accept that there are risks associated with chiropractic care and other services that are offered in this office and give my consent to the examinations that the doctor deems necessary, and to chiropractic care, spinal decompression, nutritional consultation and/or acupuncture as needed, as reported following my assessment.

Patient Name (printed) or Guardian

Relationship to patient

Patient or Legal Guardian Signature

Date

Witness Signature (Office Staff)

Date