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 then 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.

____
Reponsible Party Signature Relationship (Self/parent/spouse) Date

I. 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? ____________________________

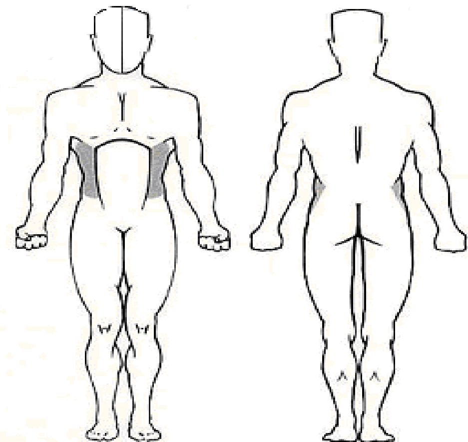
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?________

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: (___) __________

Location of primary complaint:



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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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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)

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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 diseses (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)

___Allergy	___Diarrhea	___Measles	___Rheumatic Fever	___Alcoholism	___Eczema
___Miscarriage	___Stroke	___Anemia	___Multiple Sclerosis	___HIV (AIDS)	___Gout
___Arteriosclerosis	___Emphysema	___Mumps	___Sinus Problems	___Arthritis	___Neuritis
___High Blood Pressure	___Asthma	___Nervousness	___Thryroid Problems	___Ulcers	___Cancer
___Heart Disease	___Depression	___Convulsions	___Venereal Disease	___Malaria	___Pleurisy
___Constipation	___Pneumonia	___Cold Sores	___Whooping Cough	___Polio	___Neck Pain
___Gall Bladder Problems	___Migraines	___Headaches	___Menstrual Cramps	___Back Pain	___Epilepsy
___Irregular Periods	___ Heart Attack	___Tuberculosis	___Low Blood Sugar	___ Diabetes	___Ringing in Ears

___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 complicationhs 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

Congential anomolies/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 healh 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 furhter 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