Just Health Center

Chiropractic and Wellness

1100 Rayford Rd Ste 300
Spring, Texas 77386
P: 281-367-7275
F: 281-367-7313

Dr. Linh Hua, DC
Dr. Ricerio De Leon, DC, NP

Welcome to the Office!

Just Health Center Pediatric New Patient Forms Age Infant - School Aged

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

Address: _____

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

Primary Phone: _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐Male ☐ Female ☐ Other

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

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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: _____

Surgeri _____

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

Birthing Location: ☐ Home ☐ Birthing Center ☐ Hospital

Medications During Pregnancy/Labor/Delivery: _____

Problems During Labor/ Delivery _____

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

APGAR Scores _____ ☐ Jaundice (yellow) ☐ Cyanosis (blue)

Congenital Anomalies / Defects? (explain)_____

Delivery/Birth History: _____

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

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	☐ e e t D a ea	☐ a e t e e t a
☐ Respiratory Tract Infections	☐ t at	☐ e t e e e
☐ Sinus Problems	☐ at e e	☐ et a a a t
☐ Ear Infections	☐ ea a e a e	☐ e t a e e
☐ Tonsillitis	☐ e a	☐ e ett
☐ Strep Throat	☐ t ea t	☐ ee e
☐ Frequent Colds / Croup	☐ e ee e e	☐ t e
☐ Recurrent Fevers	☐ a a	☐ e a
☐ Eczema	☐ a	☐ e e e
☐ Rashes	☐	☐ e e
☐ e e	☐ e e a t	☐ e a
☐ e t t e	☐	☐ DD D D
☐ D e t e e	☐ e e t e	☐ t D

☐ a ☐ t e ea e t ☐ t e ______________ ☐ t e ________________

☐ e e te a e e t a e e t a ea t t

☐ e ____

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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 through a chiropractic evaluation!

Consent to Evaluation and Treatment of a Minor Child

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Consent To Treatments

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INITIALS

________________________________ Signature of Individual

________________________________ Date

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Just Health Center

Chiropractic and Wellness

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The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice:a) a postcard mailed to me at the address provided by me and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI which includes information about my health or condition and the treatment provided to me in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

at e_____ Date_____

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Financial Policy

Initials

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Me a e- a a Me a e at e t e ta t at ee t e t e e t Me a e nsurance a a e a nsurance a t e e e t a e t e e at a e a a e t e e a t e e t e e t t a t e a a e a t e e a a t t e e a e e e t *As per medicare guidelines, any chronic conditions treated by chiropractic, run a possibility of not being paid for by Medicare. "The manipulation codes 98940, 98941, 98942 may be denied by Medicare if deemed a chronic condition." If treatment is denied, payment is your responsibility or your secondary insurance if applicable.*

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Just Health Center

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