ADJUST
CHIROPRACTIC HEALTH CENTER

Drs. Marissa & Jason Abaza
85 Green Pond Road, Unit 3
Rockaway, NJ 07866
Phone: 973.957-0836
www.adjustNJ.com

Pediatric
School Aged Children

Practice Member Information _____ File _____

Child's Name: _____ M _____ D _____ Y _____
Parent's/Guardian's Names: _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
How did you hear about us? _____
Height (of child): _____ Weight (of child): _____ Birth Date: M ____ D ____ Y _____ Age: ____ Sex: ☐ M ☐ F
Siblings and ages: _____ _____ _____ _____
Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact
Name: _____ Relationship to child: _____
Phone number: _____ Alternate phone number: _____

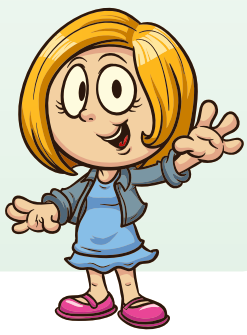
Family Doctor
Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?



- ☐ He/She is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called ***vertebrae.*** Many of the common health challenges that adults experience have their origins during the ***developmental years,*** some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins and emotional stress.*** The result may be misalignment to the spinal column and damage to the nervous system in a condition called ***Vertebral Subluxation.*** Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal.***

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	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	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PDD

Do you have a specific concern that brings you in?
☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.
☐ Yes: _____

If yes, please answer the following questions:
Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____
Is it getting better, worse or staying the same? _____ Was the onset sudden or gradual? _____
Have you seen other health professionals regarding this complaint?
☐ No ☐ if Yes, whom? _____
What treatment did they use? _____
Has your child taken any medication for this complaint? . . . . . ☐ No ☐ Yes _____
Has your child ever experienced this complaint before? . . . . . ☐ No ☐ Yes _____
Did they receive any treatment at the time? . . . . . ☐ No ☐ Yes _____
Has your child had x-rays in relation to the current complaint? . . ☐ No ☐ Yes _____

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown
Complications during pregnancy: ☐ No ☐ Yes (Brief description) _____
Ultrasounds during pregnancy: ☐ No ☐ Yes, if so, how many? _____
Medications during pregnancy: ☐ No ☐ Yes _____
If so which ones and how often? (include OTC): _____
Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ No ☐ Yes _____

Birth Experience

Location of Birth: ☐Home ☐Hospital ☐ Birthing Centre ☐Other _____
Birth Attendants: ☐Doula ☐Midwife ☐GP ☐OB ☐Other _____
Medications during labor / delivery (including IV antibiotics) ☐No ☐ Yes_____
Was Pitocin used to induce / speed up labor? ☐ No☐ Yes
Were your membranes ruptured by a medical professional? ☐No ☐ Yes
Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐No ☐Yes ☐Unsure
If yes, please describe: ☐Breech ☐Transverse ☐Face / Brow presentation
Was your delivery vaginal or C-section? _____ If it was a C-section, was it planned or emergency? _____
If it was vaginal, was the baby presented: ☐Head ☐Face ☐Breech
Were any of the following interventions used during delivery? ☐Forceps ☐Vacuum Extraction ☐Other
Were there any complications during delivery? ☐Yes ☐No
If yes, please specify:_____
How long was the labor from the first regular contractions to the birth? _____ Hours
How long was the second stage (the pushing phase) of the labor?_____ Hours
Was the baby born with any purple markings / bruising on their face or head? ☐No ☐Yes
Any concerns about misshapen head at birth? ☐No ☐Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ___w ___d / Birth Weight: ___lbs___oz / Birth Length: ____Inches
If known, APGAR scores at: 1 minute_____ /10 5 minutes _____ /10
Was the baby ever administered to Neonatal Intensive Care? ☐No ☐ Yes
If yes, for how long and why?_____
Was any medication given to the baby at birth? ☐Yes ☐No ☐Unsure
If yes, what medication and why? _____
Was your child exclusively breastfed? ☐No ☐Yes _____months
Was your child breastfed + formula fed? ☐No ☐Yes_____months
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐No ☐Yes
What age did you introduce solid foods to your child?_____ months
Did you introduce cereal or grains within your child's first year? ☐No ☐Yes
Did/Do you practice attachment parenting methods:
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) ☐No ☐Yes
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
☐No ☐Yes, Which ones? _____

Physical Traumas

Has your child ever fallen from any high places? . . . . . ☐No ☐Yes_____
Has your child ever been involved in a motor vehicle accident or near miss? . . . . . ☐No ☐Yes_____
Has your child been seen on an emergency basis? . . . . . ☐No ☐Yes_____
Has your child broken any bones? . . . . . ☐No ☐Yes_____
Has your child had any previous hospitalizations? . . . . . ☐No ☐Yes_____
Has your child had any previous surgeries? . . . . . ☐No ☐Yes_____
Does your child spend time using a tablet, computer or video games? . . ☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child watch tv? . . . . . ☐Never ☐Rarely ☐Daily ☐Several hrs/day
Does your child exercise? . . . . . ☐No ☐Daily ☐Weekly ☐Seasonally
Does your child play contact sports? . . . . . ☐No ☐Daily ☐Weekly ☐Seasonally
Does your child sleep on their . . . . . ☐Back ☐Belly ☐Sides (Both, Right, Left)
Does your child carry a back pack? . . . . . ☐No ☐Yes
Does it weigh less than 15% of their body weight? . . . . . ☐No ☐Yes
Do they wear their back pack on 2 shoulders? . . . . . ☐No ☐Yes ☐Sometimes
Does your child show excessive or uneven shoe wearing out? . . . . . ☐No ☐Yes
Does your child wear custom orthotics?
☐No ☐Yes, For what purpose? _____

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule
Reason for vaccination: ☐Informed decision ☐Didn't know I had a choice ☐It was recommended
Reaction(s) to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue ☐Prolonged Cry
☐Seizures ☐Developmental Regression ☐Other _____
Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)
Has your child been exposed to antibiotics? ☐No ☐Yes
If yes, how many doses in past 6 months? _____Reason _____
Were probiotics used at the same time as antibiotics? ☐No ☐Yes
Has your child been exposed to medications, including OTC: ☐No ☐Yes
If yes, which ones? _____
If yes, how many doses in past 6 months? _____Reason _____
How many glasses of water/day does your child have? . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and soda/day does your child have: . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Does your child eat gluten? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ☐No ☐Yes If yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐No ☐Yes
Does your child follow any other dietary restrictions? ☐No ☐Yes _____
Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes _____
Is your child exposed to second hand smoke? ☐No ☐Yes _____
Does your child take a probiotic daily? ☐No ☐Yes:_____ CFU's/day
Does your child take vitamin D3 daily? ☐No ☐Yes:_____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐No ☐Yes: _____mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age:
Intellectually: ☐Yes ☐No _____
Emotionally: ☐Yes ☐No _____
Physically: ☐Yes ☐No _____

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 through a chiropractic evaluation!

Consent to Evaluation of a Minor Child
I _____being the parent or legal guardian of_____,
(print name of consenting adult) (print name of minor)
hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neuro-structural shift.
- The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional impulse to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctors of chiropractic in the United States alone.
- Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

Informed Consent

I have been advised that chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your child's specific conditions, overall health, and in particular, spinal health. These procedures will assist us in determining if chiropractic care is needed, and if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your child's 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.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at ADJUST Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my child's condition(s) at any time throughout the entire clinical course of his/her care.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify ADJUST Chiropractic Health Center.

_____ _____

Parent/Guardian PRINTED Name **Child's Name**

_____ _____ / _____ / _____

Parent/Guardian Signature **Date**

Photography & Videography Release

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by ADJUST Chiropractic Health Center, LLC, or anyone authorized by ADJUST Chiropractic Health Center, LLC of any and all photographs/videos which were taken of my child, for the purposes of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of ADJUST Chiropractic Health Center, LLC, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize ADJUST Chiropractic Health Center, LLC to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

_____ _____ / _____ / _____

Parent/Guardian Signature **Today's Date**

X-Ray Authorization

As the child's healthcare provider, we are legally responsible for the child's chiropractic records. We must maintain a record of the child's x-rays in our files. At your request, we will provide you with a copy of the child's x-rays in our files. **The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.** The CD will be available for pick up within 72 hours of prepayment on any regular practice hours day. Shipping will be an additional fee.

Please note: X-rays are utilized in the office to help locate and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors at ADJUST Chiropractic Health Center do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice for the child.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF 5,
IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL X-RAYS.
HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I, therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ / _____ / _____

Child's Name **Birth Date**

_____ _____ / _____ / _____

Parent/Guardian Signature **Today's Date**

Notice of Privacy Practices

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to you health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled "**HIPAA**" on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes: discussion with other healthcare providers in your care.
2. Inadvertent disclosure: open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes: to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: to process a claim or aid in investigation.
5. Emergency: in the event of a medical emergency we may notify a family member.
6. For public health and safety: in order to prevent or lessen a serious or eminent threat to the health or safety of a person.
7. To Government agencies or Law Enforcement: to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons: discussion with coroner and medical examiners in the event of a patient's death.
10. Telephone calls or email and appointment reminders: **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership: in the event this practice is sold, the new owners would have access to your Personal Health Information.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records **at no charge**, when timely notice is provided (72 hours). **X-rays are original records and you are therefore not entitled to them.** If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Jason Abaza or Dr. Marissa Johnson at (973) 910-1014. If the doctors are unavailable, you may make an appointment with our receptionist to see a doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

By signing below, I am agreeing to the Terms of Acceptance, Notice of Privacy Practices, and all the terms and conditions above:

_____	_____	_____
Parent/Guardian PRINTED Name	**Parent/Guardian Signature**	**Date**