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? _____

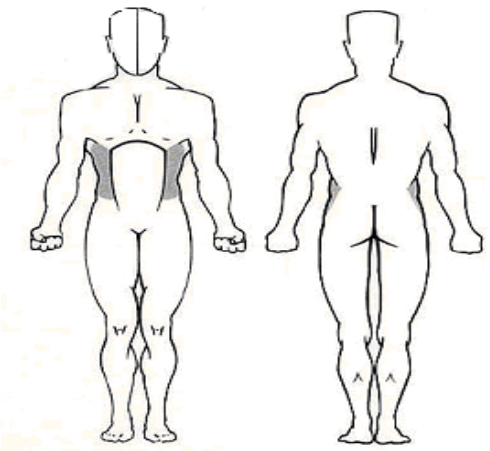
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?_____

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: _____

_____

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

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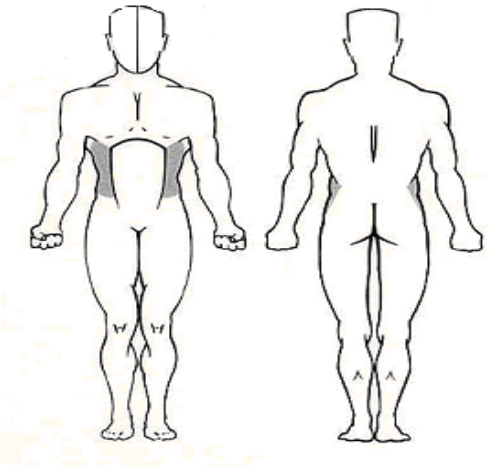

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Developmental History

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