Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic Acupuncture Automobile Injury

Todays Date:_____ Childs Name:_____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your child sleep between feeds? During the day_____ at night_____

	YES	NO	
Does your baby sleep easily?	□	□	_____
Does baby have a preferred sleeping position?	□	□	_____
Does baby cry of you change this sleeping position?	□	□	_____
Does baby have baby feeding difficulties?	□	□	_____
Is baby breast fed?	□	□	_____
If no, for how long was baby breast fed? _____**Weeks/Months**			
Does baby have a one-sided breast-feeding preference?	□	□	_____
Preferred Breast **Left/Right**			
Is baby formula fed? Which formula or milk source?	□	□	_____
Does baby frequently spit-up feeding?	□	□	_____
Does baby cry a lot? For how many hours each day?	□	□	_____
Does baby pass a lot of intestinal gas?	□	□	_____
Does baby have a preferred head position?	□	□	_____
Does baby frequently arch his/her head and neck backwards?	□	□	_____
Does baby cry or become irritable during diaper change?	□	□	_____
Has baby had any fever?	□	□	_____
Has baby had any falls?	□	□	_____
Has your child ever been in a motor vehicle accident or near miss?	□	□	_____
Has your child ever had a bone fracture or joint dislocation?	□	□	_____
Has your child had any other trauma or injuries?	□	□	_____
Does your child ever bang their head against a wall, bed, or other object?	□	□	_____

HEALTH HISTORY

Has your child had colic?	□	□	_____
Has your child had any upper respiratory infections?	□	□	_____
Has your child had earaches? If yes what age did they first occur?	□	□	_____
Do your child's earaches tend to occur in the same			

Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic Acupuncture Automobile Injury

ear? Is it right, left or both? _____	□	□	_____
Has your child had any other illnesses? Date?	□	□	_____
Is your child presently receiving any medications?	□	□	_____

PREGNANCY HISTORY

How many children do you have? _____
What was the term of your pregnancy? _____ weeks.

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING? EXPLAIN

	YES	NO	
Falls	□	□	_____
Motor Vehicle Accident(s)	□	□	_____
Near-Miss MVA	□	□	_____
High Blood Pressure	□	□	_____
Diabetes	□	□	_____
Anemia	□	□	_____
Morning Sickness	□	□	_____
Indigestion	□	□	_____
Seizures	□	□	_____
Swollen Ankles	□	□	_____
Thyroid Problems	□	□	_____
Heart Problems	□	□	_____
Back Pain	□	□	_____
Abnormal Bleeding	□	□	_____
Were you hospitalized	□	□	_____
Any other illness	□	□	_____

Any other information you wish to add about your pregnancy;

_____
_____
_____
_____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to birth? _____ hours.
How long was the 2nd stage (the pushing phase) of the labor? _____ hours.

	YES	NO	
Hospital Birth	□	□	_____

Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic Acupuncture Automobile Injury

Home Birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-Section	☐	☐	_____
Emergency C-Section	☐	☐	_____
Induced birth (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

FAMILY INFORMATION

Mother's Name: _____
Address: _____
City _____ State _____ Zip _____
Home Phone: _____ Cell:_____
Father's Name: _____
Address: _____
City _____ State _____ Zip _____
Home Phone: _____ Cell:_____

INSURANCE INFORMATION

Primary Insurance: _____
Name of Insured: _____
Date of birth of insured: _____
Secondary Insurance: _____
Name of Insured: _____
Date of birth of insured: _____

CONSENT TO TREAT: Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named above as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care regardless of what my insurance company covers. I hereby authorize Perreault Chiropractic to seek payment and authorize/assign payment directly to them from my insurance company.

PARENT GUARDIAN SIGNATURE: _____

Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic Acupuncture Automobile Injury

Consent to the Use and Disclosure of Health information for Treatment, payment, or Healthcare operations.

I understand that as part of my healthcare, Perreault Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment, and any future plans for care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a "Notice of Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Perreault Chiropractic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Perreault Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Perreault Chiropractic has already taken action in reliance thereon.

Authorization and Assignment of Benefits

I hereby authorize Perreault Chiropractic to release to my insurance company information necessary for them to process my claims for care. I also assign insurance benefits to Perreault Chiropractic as may be allowed by my insurance company. I further understand that I am fully responsible for all the charges incurred at Perreault Chiropractic regardless of my insurance coverage. Please note: We will do all we can to insure your care is covered by your insurance carrier. However, benefits quoted to us over the phone are not a guarantee of payment but a general outline of your coverage. If a problem arises we will appraise you as soon as possible and will expect you to call your insurance carrier to clear up any problems. Please keep in mind your contract is between you and your insurance carrier. We do not have any legal rights to your insurance contract – you do. Please be aware that many insurance carriers can take up to 3 months or more to process a claim.

Signature: _____ Date: _____