Newborn Patient Questionnaire

Child's Name_____Parent(s)Guardian(s)name_____

Address_____City _____State _____ Zip_____

Home Phone _____Work Phone _____Cell Phone _____

Is it ok to contact you at work? ___Yes ___No
Email: _____Birthdate _____ Age_____

Have you or your child ever had chiropractic care before? ___Yes ___No

If yes, please tell us the doctor name_____

Were you pleased with your care? ___Yes ___No
How did you hear about our office?_____

Is this appointment related to an auto accident? ___Yes ___No
Is your child receiving care from other health professionals? ___Yes ___No
If so, please name them and their specialty_____

Who is your family's primary care physician? _____

What health condition brings your child to our office _____

_____

When did the symptoms first begin? _____

_____

How did the problem start? ___Suddenly ___Gradually ___Post-injury

Is this condition ___Getting Worse ___Improving ___Intermittent ___Constant ___Not sure
What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ___Yes ___No
Please explain _____

Has your child been treated for this problem before? ___Yes ___No
Please explain_____

Pregnancy and Birth

Maternal Exposures:

Medication ___Yes ___No Explain _____

Drugs/Alcohol ___Yes ___No Explain _____

Tobacco ___Yes ___No Explain _____

Infection/Grp B strep ___Yes ___No Explain _____

Birth problems for patient:

Infection ___Yes ___No Explain _____

Breathing issues ___Yes ___No Explain _____

Low Blood Sugar ___Yes ___No Explain _____

Oxygen Use ___Yes ___No Explain _____

NICU stay ___Yes ___No Explain _____

Is the child yours by ___birth ___adoption ___stepchild ___other

Was your child born prematurely? ___Yes ___No born at _____ weeks.

Where was your child born? ___home ___birthing center ___ hospital

Child's birth was ___ Natural vaginal (no medications/interventions)

___ Vaginal with interventions

___ Induction ___ Pain medication ___ Epidural ___ Episiotomy

___ Vacuum extraction ___ Forceps

___ C-Section

___ Scheduled ___ Emergency

Birth Weight _____ Birth Length _____

Current Weight _____ Current Length _____

Birth mother's blood type? _____ Baby's blood type_____

APGAR score at birth _____ APGAR score after 5 minutes _____

Was your child alert and responsive within 12 hours of delivery? ___ Yes ___ No
If no, please explain _____

Any other problems with the birthing process?_____

Past Medical History of Your Infant

Any medications taken regularly? ___Yes ___No, Which ones?_____

Any allergic reactions to medications? ___Yes ___No, Which ones? _____

Any reactions to immunizations? ___Yes ___No, Which ones? _____

Any hospitalizations other than for birth?___Yes ___No, Explain _____

Anything else of significance? _____

Safety/ Environment

Where does your baby sleep: _____Parent's Room ____Nursery _____Sibling's room, _____other?

Feeding and Nutrition

Any feeding problems? ___Yes ___No, Explain _____

Breast or formula fed? _____ Which formula _____

If breastfeeding, how long do you plan to continue? _____

Does he/she take vitamins? ___Yes ___No, Which ones? _____

Review of systems

Any eye problems? ___Yes ___No, Explain _____

Difficult or noisy breathing? ___Yes ___No, Explain _____

Heart murmur or heart problem?___Yes ___No, Explain _____

Problem with stools (diarrhea/constipation)? ___Yes ___No, Explain _____

Is he/she irritable or colicky? ___Yes ___No, Explain _____

Any skin conditions? ___Yes ___No, Explain _____

Problem with excessive spit up? ___Yes ___No, Explain _____

Please list any other medical problems or explain above problems. _____

_____

Social History

Who lives in the child's household? __Mom __Dad _ Siblings (# ___) __Grandparents ___Other

Child's parents are __married __unmarried __ divorced __other

Mom's Occupation _____

Dad's Occupation _____

Childcare _____ Parents _____ relatives _____ daycare _____ babysitter/nanny

Days per week in childcare (not with parent) _____

Pets? __No __ Yes Explain _____

Do any household members smoke? ___Yes ___No

Family History

Asthma	___Mom ___Dad ___ Other	Allergies	___Mom ___Dad ___ Other
Anemia	___Mom ___Dad ___ Other	Blood disorder	___Mom ___Dad ___ Other
Cancer	___Mom ___Dad ___ Other	Diabetes	___Mom ___Dad ___ Other
High cholesterol	___Mom ___Dad ___ Other	High blood pressure	___Mom ___Dad ___ Other
Heart attack/disease	___Mom ___Dad ___ Other	Thyroid Disease	___Mom ___Dad ___ Other
Kidney disease	___Mom ___Dad ___ Other	Seizures	___Mom ___Dad ___ Other
Migraines	___Mom ___Dad ___ Other	Autism	___Mom ___Dad ___ Other
Depression/anxiety	___Mom ___Dad ___ Other	Alcoholism	___Mom ___Dad ___ Other
ADD/ADHD	___Mom ___Dad ___ Other	Other issues	_____

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____

_____

_____

Parent(s)/Guardian Signature Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOE MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

RiverPath Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment
We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Workers Compensation
We may disclose your health information to as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reaction to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by the Institutions Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to health or safety of a particular person or to the general public.

Marketing
We may contact you for marketing purposes of fundraising purposes.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that RiverPath Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to the restriction you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that RiverPath Chiropractic amend your protected health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by RiverPath Chiropractic. you have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

RiverPath Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, RiverPath Chiropractic is required by laws to comply with this notice.

RiverPath Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. I f you have questions about any part of this notice or if you want more information about your privacy rights, please contact Drs. Kim and Chris McHugh (DCs), on their office phone at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights or how RiverPath Chiropractic has handled your health information should be directed to Drs. Kim and Chris McHugh, by calling their office at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington DC 20201

This notice is effective as of March 1, 2016.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide RiverPath Chiropractic with my authorization and consent to use and disclose my protected healthcare information for the use purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Authorized Facility Signature Date

License Notice

As of August 11, 2022, I, Christopher Michael McHugh, have chosen not to renew the chiropractic license with the STATE OF CALIFORNIA. There are pros and cons to this decision.

Pros: I am free to do what is best for you. I am able to learn, study, and grow based on what I know and feel to be the most important.

Cons: I am not able to take health or car insurance. I am unable to write super-bills.

I will continue to accept the following:

- Cash
- Gold/Silver
- Trades
- Credit/Debit/HSA/CareCredit

I will continue to serve you and your family with my fullest love and attention.

_____ _____

Signature Date