INNATE LIFE
CHIROPRACTIC

NEWBORN VITAL INFORMATION

Date_____

All information is strictly confidential and is only available for Innate Life Chiropractic staff to serve you best.

First Name:_____ Last Name:_____

Age:_____ Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female

Parent/Guardian's Name:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone: (_____) _____Cell Phone: (_____) _____

Work Phone: (_____) _____ Email:_____

How were you referred to Innate Life Chiropractic?_____

Reason(s) for seeking services at Innate Life Chiropractic:_____

What goals do you and your child have? (Please check all that apply)

☐Restore Health
☐Maintain Health
☐Wellness & Prevention
☐Symptom Relief/Temporary Relief
☐Improved Feeding & Digestion
☐More energy
☐Better sleep
☐Cease medication
☐Expand Level of Well-Being
☐Reach full potential

PERINATAL HISTORY

Type of Birth (check all that apply):

☐Normal/Vaginal ☐Forceps ☐Breech ☐Epidural ☐Drug Induced

☐Vacuum Extraction ☐Cord wrapped around neck ☐Hospital ☐Cesarean ☐Home

At how many weeks was your child born?_____Birth Weight _____ Current Weight_____

Challenge(s) during pregnancy?_____

_____

Challenge(s) with labor/delivery?_____

_____

Present at Birth? ☐Jaundice (yellow) ☐Cyanosis (blue) ☐Congenital

Anomalies:_____

APGAR score at birth:_____ APGAR score after 5 minutes: _____

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Infant Feeding: ☐Breast ☐Bottle ☐Formula

Quality of Sleep: ☐Good ☐Fair ☐Poor

Immunization History_____

Any childhood diseases?_____

Purpose of Last Visit to MD_____Date_____

Has your child ever had:

☐ Surgery -- if so, when & for what condition(s)?_____

☐ Hospitalizations -- if so, when & for what condition(s):_____

☐ Chronic Illness(es) -- Explain: _____

☐ Emergency Visits -- Explain: _____

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you? _____

_____

CONSENT TO TREAT MINOR

I certify that I, _____, am the child's parent and/or legal guardian and responsible for making their health care decisions. I hereby authorize Dr. Nathan Gerowitz and whomever he may designate as his assistants to administer care, as he as deems necessary to my child _____. I also grant permission for Dr. Nathan Gerowitz to provide care for my child if I am not present.

Date _____/_____/_____ Signed_____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this practice to collect for services as they are rendered, unless other financial arrangements are made. If at any point, a patient must cancel the remaining of their care plan they are entitled to a refund of the remaining balance. A refund will not be given for services that have been previously rendered.

Patient Signature _____ Date _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each client understand both the objective and the method used. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is to improve and optimize the health and wellbeing of the spine and nerve system, through the adjustment of Vertebral Subluxations

Health

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Subluxation

A misalignment of one or more of the 24 vertebra in the spinal column which causes altered function of the nervous system and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments, either by hand or instrument, to the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to clear major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to clear subluxations.

I, _____ (print name) have read and fully understand the above statements.

Patient Signature _____ Date _____