WELCOME TO OUR OFFICE!

It is our pleasure to partner with you in caring for your child's health. Our commitment is to provide him/her with a foundational level of health through specific and individualized chiropractic care. To help us serve you better, please complete the following.

Pediatric Health Record

Patient Name_____Date_____

Parents/Guardians_____

Siblings (Names/Ages)_____

Address_____City/State_____

Zip_____ Phone_____ Email_____

Age_____Birthdate_____Sex_____Weight_____Height_____

Whom may we thank for referring you?

_____

Please Describe the Purpose of this Visit:

_____

_____

_____

Experience with Chiropractic:

Has any adult in your family seen a Chiropractor?_____ Any child?_____

Dr.'s Name/Location:_____Last visit: _____

Reason for those visits:_____Frequency:_____

Were you aware that doctors of chiropractic work with the nervous system? _____

Health Practices:

Name of Pediatrician: _____ Frequency of visits: _____

Date of last visit: _____Reason: _____

Number of doses of antibiotics your child has taken:

During the past six months: _____ Total during lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past six months: _____ Total during lifetime: _____

List: _____

Vaccination History: _____ Any reactions: _____

Have you withheld any vaccine? _____ Why? _____

Dietary Supplements?_____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? _____Y _____N List: _____

Ultrasounds During Pregnancy? _____Y _____N Number: _____

Medications During Pregnancy/Delivery? _____Y _____N List: _____

Tobacco/Alcohol Use During Pregnancy: _____Y _____N

Location of Birth: _____ Hospital _____Birthing Center _____Home

Birth Interventions:

_____ Forceps _____Vacuum Extraction _____Cesarian (Emergency or Planned?)

Complications during delivery? _____Y _____N List_____

Genetic Disorders or disabilities? _____Y _____N List _____

Birth Weight: _____ Birth Length: _____ Apgar Scores: _____-_____

Feeding History:

Breast fed: _____Y _____N How long: _____

Formula fed: _____Y _____N How long: _____ Type: _____

Introduced solids at _____ months. Introduced cow's milk at _____ months.

Food allergies or intolerances: _____Y _____N List: _____

Developmental History:

Periods of rapid growth and development are key opportunities to have your child's spine checked for vertebral subluxation (spinal nerve interference) by a pediatric chiropractor.

At what age was your child able to:

_____ Respond to sound	_____ Sit up
_____ Respond to visual stimuli	_____ Cross crawl
_____ Hold head up	_____ Stand alone
_____ Roll over	_____ Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first two year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? _____Y _____N

Is/Has your child been involved in any impact or contact type sports?

_____Y _____N List: _____

Has your child ever been involved in a car accident? _____Y _____N

Describe: _____

Has your child ever been seen on an emergency basis? ____Y ____N

Describe: _____

Other traumas not described above? _____Y _____N

Describe: _____

Prior surgery: _____Y _____N Describe: _____

Recent History:

Please circle any of the following conditions he/she has suffered from in the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds
Headaches	Asthma/Allergies	ADHD	Digestive Problems
Recurring Fevers	Colic	Bed Wetting	Car Accident
Temper Tantrums	Acid Reflux	Other: _____	

We are here to serve you, and encourage you to ask questions.

Your participation is vital and will help determine your results.

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by a handheld instrument. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Acknowledgement of Receipt of Privacy Notice

In compliance with federal law, a copy of the national Standards for Privacy of Individually Identifiable Health Information is available upon request. The Privacy Notice describes in detail how a member's health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of a member's health information, whether it is maintained on paper or electronically, and regardless of how it is communicated.

A copy of the Privacy Notice has been made available to me.

Name (print)_____ Date_____
Signature_____ Date of Birth_____

When member is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Representative_____Date_____
Print Name_____ Relationship to Member_____