Pediatric Patient Personal Data

Today's Date: _____

Parent/Guardian Information

Name: _____ Preferred Name: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Cell Phone: _____ Work: _____ Home: _____
E-Mail: _____
Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Other: _____
Name of Spouse: _____ Number of Children: _____
Employed: ☐ Y ☐ N
Employer: _____ Occupation: _____
*Referred by: _____ ☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor

Emergency Contact Information

Name: (*First Last*) _____ Cell Phone: _____
Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____
Primary Care Physician: _____ Doctor's Phone: _____

Patient Information

Name: _____ Preferred Name: _____
Date of Birth: _____ Gender: ☐ M ☐ F

What is the main reason for today's visit? _____
Onset was: ☐ Gradual ☐ Sudden If sudden, was it associated with an event?
_____
How frequent is the complaint present? ☐ Off & On ☐ Constant
Does anything make the complaint better?
☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Stretching ☐ OTC ☐ Other_____
Does anything make the complaint worse?
☐ Sit ☐ Stand ☐ Walk ☐ Lying ☐ Sleep ☐ Overuse ☐ Other _____
How does the problem affect your child's body function and daily activities?
_____
List any other care your child has undergone with regard to this complaint, including medications and vitamins: _____
_____
Any other health problems or concerns? _____
_____

Birth History

Duration of Pregnancy: _____ Hours in Labor: _____ Birth Position: _____
Birth weight: _____ Birth Length: _____ APGAR Score: _____
Was the birth assisted? ☐ Induced Labor ☐ C-Section ☐ Epidural ☐ Forceps ☐ Vacuum extraction
NICU care given? Please explain: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Pediatric Patient Personal Data Cont'd

Is/was the baby breastfed? _____ If yes, how long? _____
Is/was formula introduced? _____ If yes, how long? _____ Brand of formula: _____
At what age was cow or goat milk introduced? _____
At what age were solid foods introduced? _____
Did your child receive any vaccinations? _____ Any adverse reactions? _____
Has your child had any antibiotics? _____ If yes, last date taken: _____
Has the child ever needed stitches or obtain a fracture? Please explain: _____
Has the child ever been hospitalized? Please explain: _____

Consent for Chiropractic Services

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 affect 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 or dysfunction, 10% of the central nervous system is pain sensation, 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. 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.

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), sometimes resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Therefore by signing below:
I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;
I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____