

# PEDIATRIC CONSULTATION

(10 years old or older)

Name \_\_\_\_\_ Date \_\_\_\_\_

## Patient information

Child's Name \_\_\_\_\_ Sex: Male / Female  
Child's SS#: \_\_\_\_\_ Child's Birthday: \_\_\_\_\_  
Parent or Legal Guardian Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Where do prefer to receive calls? \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Person to contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_  
Pediatician? \_\_\_\_\_ Phone: \_\_\_\_\_

## Responsible Party

Name of person responsible for this account: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Method of payment of today's charges:  Cash  Check  Charge

**The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebra. What I want to do now is discover several of yours.**

What was your child's birth like? \_\_\_\_\_

How long was the entire labor? \_\_\_\_\_ How long did you actually push? \_\_\_\_\_

Were you induced? Yes No Epidural? Yes No C-Section? Yes No

Was there any pulling on the head? Yes No Any vacuum extraction? Yes No

Has your child been immunized? Yes No Any reactions? Yes No

Explain any reactions: \_\_\_\_\_

**47% of all children fall on their heads by the age of one and they have at least 200 major falls by the age of 8 years old.**

When was the child's most recent fall? \_\_\_\_\_

Was any care given? \_\_\_\_\_ Was s/he checked by a chiropractor? \_\_\_\_\_

And the fall before that? \_\_\_\_\_ Any care given? \_\_\_\_\_

**What sports or recreational activities does s/he do?** \_\_\_\_\_

When was the child's most recent stress, strain, or injury while doing these activities?  
\_\_\_\_\_

Care given? \_\_\_\_\_

**Has the child been involved in a motor vehicle accident as a passenger?** Yes No

Briefly describe: \_\_\_\_\_

Any treatment received? \_\_\_\_\_ Chiropractic? \_\_\_\_\_

**These sound important. Thank you for explaining your child's history of accidents and traumas. This will help the doctor better understand the case. What I want to do now is ask you a few questions regarding your child's current health concerns.**

Does your child have any health concerns? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

**Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.**

Are there any other conditions that your child is or was experiencing?  
\_\_\_\_\_

How long? \_\_\_\_\_

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. How often does your child have this condition? \_\_\_\_\_

Any medications? \_\_\_\_\_

Is there anything else that you feel is important that has not been addressed on this form?  
\_\_\_\_\_  
\_\_\_\_\_

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**Name of Patient**

**I hereby grant permission to Team Chiropractic to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.**

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**Signature of Parent or legal guardian** **Date**

*Authorization*  
*I the undersigned have read and answered the above information to the best of my knowledge. The above questions have been accurately answered on behalf of my child. I understand that providing incorrect information can be dangerous to my child's health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such said chiropractic care to third party payers and/or health practitioners. Providing my insurance provides for the care of my child, I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand, provided my insurance is accepted and provides for my child, that the carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on behalf of my dependents.*

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**Signature of parent or legal guardian** **Date**

**PATIENT CONSENT**

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

“I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein.”

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**Patient Name, printed**

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**Guardian Signature**

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**Date**

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# Parental Consent

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I, \_\_\_\_\_, hereby consent to Team Chiropractic permission to call my home, cell, and work number for appointment reminders and routine office needs regarding my child's account.

I hereby consent for Team Chiropractic to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_

I hereby revoke any information to be given to the following family members regarding any routine office needs here at Team Chiropractic:

\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_  
\_\_\_\_\_  
Relation: \_\_\_\_\_

Due to the privacy act created by the Centers for Medicare and Medicaid, this office is required to have your signature allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

“I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein.”

\_\_\_\_\_  
Patient Name, printed

\_\_\_\_\_  
Legal Guardian/Parent Signature

\_\_\_\_\_  
Date

## CHIROPRACTIC ORIENTATION

When a patient seeks chiropractic health care 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: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

**Adjustment:** the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

**Health:** a state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination 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 eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, \_\_\_\_\_, have read and fully understand the above statements.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*