PEDIATRIC CONSULTATION

Patient information

Child's Name ___________________________ Sex: M / F Date: ____________
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: _____________
Pediatrician? ______________________________ 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

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.

____
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.

____
Signature of parent or legal guardian Date

PREGNANCY HISTORY

Mother's Name______________________ How many children do you have? __________

What was the term of your pregnancy? ________________ weeks

During Your Pregnancy, Did You Have Any Of The Following?

	Yes	No	
Falls?	☐	☐	____________________
Motor Vehicle Accidents?	☐	☐	____________________
Near-miss MVA	☐	☐	____________________
High B.P.	☐	☐	____________________
Diabetes	☐	☐	____________________
Anemia	☐	☐	____________________
Morning sickness	☐	☐	____________________
Indigestion	☐	☐	____________________
Seizures	☐	☐	____________________
Swollen ankles	☐	☐	____________________
Thyroid problems	☐	☐	____________________
Heart problems	☐	☐	____________________
Back pain	☐	☐	____________________
Abnormal bleeding	☐	☐	____________________
Were you hospitalized	☐	☐	____________________
Any other illnesses	☐	☐	____________________

During Your Pregnancy, Did You Use Any Of The Following:

	Yes	No	
Tobacco	☐	☐	____________________
Alcohol	☐	☐	____________________
Non-prescribed drugs	☐	☐	____________________
Prescription medications	☐	☐	Medication ______________Reason____________
Over-the-counter meds	☐	☐	Medication ______________Reason____________

BIRTH HISTORY (Labor and Delivery)

How long was the labor from the first regular contractions to the birth?________ hours

How long was the 2nd stage (the pushing phase) of the labor? ____________hours

	Yes	No		Yes	No
Hospital Birth	☐	☐	Vaginal Delivery	☐	☐
Home Birth	☐	☐	Planned C-section	☐	☐
Midwife assisted	☐	☐	Emergency C-section	☐	☐
Was birth induced (Pitocin)	☐	☐	Anesthesia administered	☐	☐
Forceps delivery	☐	☐	Fetal distress	☐	☐
Vacuum extraction	☐	☐	Meconium staining	☐	☐
Head presentation	☐	☐			
Face presentation	☐	☐			
Breech presentation	☐	☐			

Baby's Condition Immediately After Birth

Apgar Scores: At 1 minute____/10 At 5 minutes ___/10

Baby's crying Baby cried immediately after birth_____
Cried strongly ___ Weak cry___ Did not cry for ___ minutes

Baby's color Pink all over ___ Blue face___ Blue hands/feet___

Baby's activity Arms and legs actively moving ___ Floppy baby ___

Intensive care Was required ___ Days in Neonatal Intensive Care ___

Medications given at birth? ______________________________________
Vaccines administered____

Birth weight _______lbs/kgs Birth length _______inc/cms Baby home on day ____

PRE-SCHOOL CHILD HISTORY
(3 TO 5 YEARS)

Yes No
☐ ☐ Does your child complain of pain or discomfort? If yes when did this occur? ________

Was onset sudden ☐ or gradual ☐ Is problem constant ☐ or intermittent ☐

Yes No
☐ ☐ Has your child ever had this problem before? ___________________________________

Yes No
☐ ☐ Has your child ever been treated for this problem? By whom _____________________

Yes No
☐ ☐ Has your child previously had chiropractic care? Previous chiropractor _____________

Health History

Yes No
☐ ☐ Does your child ever complain of back or neck pain? ___________________________

Yes No
☐ ☐ Does your child ever complain of pains in the legs or arms?______________________

Yes No
☐ ☐ Does your child ever complain of headaches?___________________________________

Yes No
☐ ☐ Has your child had asthma?____

Yes No
☐ ☐ Is your child allergic to anything?____

Yes No
☐ ☐ Are there any smokers in the child's home?_____________________________________

Yes No
☐ ☐ Has your child had any earaches? At what age did the child's first earache occur? ___
In which ear do your child's earaches usually occur? ☐ Right ☐ Left ☐ Both

Yes No
☐ ☐ Is your child presently taking any prescribed medication (s)? ____________________

Please list any other illness (s) which have been a concern for your child __________________

Yes No
☐ ☐ Do you have any other concerns about your child's health? _____________________
____

Trauma

Yes No Has your child had any recent falls?
☐ ☐
Describe the trauma and the date it occurred__________________________________

Yes No
☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?

Yes No
☐ ☐ Has your child ever fallen down stairs or fallen from a significant height? __________

Yes No
☐ ☐ Has your child ever been in a motor vehicle-collision or near miss? ________________

Yes No
☐ ☐ Has your child ever had a bone fracture or dislocation?__________________________

Yes No
☐ ☐ Has your child had any other trauma or injuries? ______________________________

Yes No
☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?

Nutrition

Yes No
☐ ☐ Do you have any concerns about your child's diet? _____________________________

Yes No
☐ ☐ Does your child have any food allergies? _____________________________________

Yes No
☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? _________

Yes No
☐ ☐ Does your child eliminate stools each day? ___________________________________

For how many months was your child breast-fed? ___________________________________
What does your child usually eat for breakfast?_____________________________________
What does your child usually eat for lunch?____
What does your child usually eat for dinner? _______________________________________
What does your child usually eat for snacks?_______________________________________
How much cow's milk does your child drink each day_________________________________
What is your child's favorite food? ____
What type of fast foods does your child like to eat? _________________________________

Parent Consent

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*