

PEDIATRIC CONSULTATION

(6 years to 9 years old)

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? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Motor Vehicle Accidents? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Near-miss MVA | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High B.P. | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Morning sickness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Indigestion | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Swollen ankles | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Back pain | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Abnormal bleeding | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Were you hospitalized | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Any other illnesses | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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

| | Yes | No | |
|--------------------------|--------------------------|--------------------------|-------------------------------|
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Non-prescribed drugs | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Prescription medications | <input type="checkbox"/> | <input type="checkbox"/> | Medication _____ Reason _____ |
| Over-the-counter meds | <input type="checkbox"/> | <input type="checkbox"/> | 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 | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Delivery | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Birth | <input type="checkbox"/> | <input type="checkbox"/> | Planned C-section | <input type="checkbox"/> | <input type="checkbox"/> |
| Midwife assisted | <input type="checkbox"/> | <input type="checkbox"/> | Emergency C-section | <input type="checkbox"/> | <input type="checkbox"/> |
| Was birth induced (Pitocin) | <input type="checkbox"/> | <input type="checkbox"/> | Anesthesia administered | <input type="checkbox"/> | <input type="checkbox"/> |
| Forceps delivery | <input type="checkbox"/> | <input type="checkbox"/> | Fetal distress | <input type="checkbox"/> | <input type="checkbox"/> |
| Vacuum extraction | <input type="checkbox"/> | <input type="checkbox"/> | Meconium staining | <input type="checkbox"/> | <input type="checkbox"/> |
| Head presentation | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Face presentation | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Breech presentation | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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 _____

School-age child history

6 Years and Older

Yes No

- Have you ever had this problem before? _____
- Have you previously been treated for this problem? Doctors' name _____
- Have you ever been to a chiropractor? When? _____

About Your Health

In the past year have you had any of the following

Yes No

- Back or neck pain? _____
- Pains in the legs or arms? _____
- Headaches? _____
- Asthma? _____
- Allergies? _____
- Earaches? _____
- Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____
- Do you ever have a problem bedwetting? _____
- Have you ever been in a motor vehicle accident? _____
- Have you ever had any broken bones? _____
- Have you ever had any surgeries? _____
- Are you presently taking any medications? _____
- Do you have any other health problems? _____

About Your Lifestyle

What grade are in at school? _____

How do you carry your school book? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day to you watch TV? _____

How many hours each day to you use a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

About Your Diet

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How many sodas or colas do you drink each day? _____

How much water do you drink each day? _____

How often do you eat fast food items? _____

Parental 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