TEAM
CHIROPRACTIC
& Sports Medicine, P.A.

PEDIATRIC CONSULTATION

(3 years to 5 years old)

Patient information

Child's Name _____ Sex: M / F Date: _____
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: _____

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
Circle all that apply:

Hospital Birth
Home Birth
Midwife assisted

Vaginal Delivery
Planned C-section
Emergency C-section

Was birth induced (Pitocin)
Forceps delivery
Vacuum extraction

Anesthesia administered
Fetal distress
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: _____in/cm 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 problem: sudden ☐ gradual ☐ Is problem: constant ☐ intermittent ☐
☐ ☐ Has your child ever had this problem before? _____
☐ ☐ Has your child ever been treated for this problem? By whom _____
☐ ☐ Has your child previously had chiropractic care? Previous chiropractor _____

Health History

Yes No
☐ ☐ Does your child ever complain of back or neck pain? _____
☐ ☐ Does your child ever complain of pains in the legs or arms?_____
☐ ☐ Does your child ever complain of headaches?_____
☐ ☐ Has your child had asthma?_____
☐ ☐ Is your child allergic to anything?_____
☐ ☐ Are there any smokers in the child's home?_____
☐ ☐ 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
☐ ☐ Is your child presently taking any prescribed medication (s)? _____
☐ ☐ 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_____
☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?
☐ ☐ Has your child ever fallen down stairs or fallen from a significant height? _____
☐ ☐ Has your child ever been in a motor vehicle-collision or near miss? _____
☐ ☐ Has your child ever had a bone fracture or dislocation?_____
☐ ☐ Has your child had any other trauma or injuries? _____
☐ ☐ 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? _____
☐	☐	Does your child have any food allergies? _____
☐	☐	Does your child have any persistent or intermittently occurring skin rashes? _____
☐	☐	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*