



TEAM  
**CHIROPRACTIC**  
& Sports Medicine, P.A.

## PEDIATRIC CONSULTATION

(6 years to 9 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: \_\_\_\_\_

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 2<sup>nd</sup> 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 \_\_\_\_\_

### **School-age child history** **6 Years and Older**

Current health concern? \_\_\_\_\_

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had this problem before? _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you previously been treated for this problem? Doctors' name _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been to a chiropractor? When? _____                      |

### **About Your Health**

In the past year have you had any of the following

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Back or neck pain? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pains in the legs or arms? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Earaches? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever have a problem bedwetting? _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in a motor vehicle accident? _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

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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: \_\_\_\_\_

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: \_\_\_\_\_

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*