# PEDIATRIC CONSULTATION

*(NEWBORN TO 1 MONTH 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 ____

**NEWBORN HISTORY**

How many hours does your baby sleep between feedings? During day _____ Night _____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Does your baby go to sleep easily?_____________________________________ |
| ☐ | ☐ | Does baby have a preferred sleeping position?____________________________ |
| ☐ | ☐ | Does baby cry if you change this sleeping position?_________________________ |
| ☐ | ☐ | Does baby have any feeding difficulties?_________________________________ |
| ☐ | ☐ | Is baby being breast fed? If no, for how long was baby breast fed?____wks. mos. |
| ☐ | ☐ | Does baby have a one-sided breast preference? Preferred breast: Left Right |
| ☐ | ☐ | Is baby formula fed? Which formula or other milk source?___________________ |
| ☐ | ☐ | Does baby frequently spit up after feeding? ______________________________ |
| ☐ | ☐ | Does your baby cry a lot? For how many hours each day? ___________________ |
| ☐ | ☐ | Does baby pass a lot of intestinal gas?___________________________________ |
| ☐ | ☐ | Does baby have a preferred head position?_________________________________ |
| ☐ | ☐ | Does baby frequently arch his/her head and neck backwards?_________________ |
| ☐ | ☐ | Does baby cry or become irritable during diaper change?_____________________ |
| ☐ | ☐ | Has baby ever had a fever? ______________________________________________ |
| ☐ | ☐ | Has baby ever had any falls?_____________________________________________ |
| ☐ | ☐ | Has baby ever been in a car accident or near-miss?__________________________ |
| ☐ | ☐ | Has baby had any other trauma?__________________________________________ |
| ☐ | ☐ | Has your baby been vaccinated?__________________________________________ |
| ☐ | ☐ | Do you have any other concerns you wish to discuss? ______________________ |

_______________________________________________________________________

# 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*