TEAM
CHIROPRACTIC
& Sports Medicine, P.A.

PEDIATRIC CONSULTATION

(NEWBORN TO 2 YEARS)

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 <u>ONLY</u> 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? _____ _____

INFANT <u>ONLY</u> HISTORY

Nutrition

Yes	No	
☐	☐	Is your child still being breast fed? If no, for how long was he/she breast fed?_____ If still breast fed, how much cow's milk does the mother consume each day?___
☐	☐	Is your child formula fed? Which formula or other milk source?_____
☐	☐	Is your baby eating solid food? What foods does his/her diet contain? _____ What is baby's favorite food?_____
☐	☐	Does your baby have any feeding difficulties?_____

☐ ☐ Does your baby have any digestive disturbances?_____
☐ ☐ Does baby have any food allergies? _____
☐ ☐ Does your baby have any persistent or intermittent skin rashes?_____
☐ ☐ Is your baby receiving any vitamin supplements?_____

Trauma

Yes No
☐ ☐ Has your baby had any recent falls or trauma?
Describe the date and the trauma_____
☐ ☐ Has your baby ever fallen down stairs or fallen from any height?_____
☐ ☐ Has baby ever had a bone fracture or joint dislocation? _____
☐ ☐ Has baby had any other trauma or injuries?_____
☐ ☐ Does your baby ever bang his/her head repeatedly against a wall, bed or other object?_____

Developmental Milestones

Please indicate the most complex skill your child can perform in each section
In each section the tasks are arranged in order of increasing developmental age.

Gross Motor Skills
☐ able to hold head up from the table momentarily
☐ head and shoulder can be supported by the forearms
☐ infant can be pulled up into a sitting position by the hands
☐ sits unsupported in the upright position
☐ head and shoulders can be supported by the arms
☐ rolls from prone to supine position
☐ crawls
☐ stands holding onto furniture
☐ walks with someone holding onto one hand
☐ walks unassisted
☐ negotiates stairs placing 2 feet on each step
☐ climbs stairs using one foot on each step
☐ walks down stairs with one foot on each step
☐ hops on one foot

Social Skills
☐ smiles
☐ reaches for familiar objects
☐ plays with hands
☐ plays with feet
☐ clearly shows joy and pleasure

☐ feeds self with fingers
☐ plays peek-a-boo
☐ understands yes and no

Fine Motor Skills
☐ Primitive grasp reflex present
☐ holds and shakes a rattle in hand
☐ grasps objects independently
☐ moves object from one hand to the other
☐ self-feeding, can hold and eat a cookie
☐ checks object by placing them in mouth
☐ picks up object with thumb and index
☐ turns 2 to 3 pages of a book at a time
☐ builds a tower containing at least 5 blocks
☐ builds a tower containing 10 blocks

Communication Skills
☐ makes cooing sounds
☐ laughs
☐ uses one syllable words such as “da”
☐ uses 2 syllable words such as “dada”
☐ uses 2 to 3 syllable words
☐ uses 2 to 3 word phrases

Adaptive Skills
☐ feeds from a cup unassisted
☐ holds own bottle
☐ feeds self with utensils
☐ able to identify and match some colors
☐ copies a circle
☐ copies a cross

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: _____

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

ORIENTATION & INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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. 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. **Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

Allow us to introduce some terms you need to be familiar with as you receive your chiropractic care:

- **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 and extremities. **Dr. Lawrence D. Dodd and his associates** will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop." Cold packs, diet, nutritional supplementation, exercises, traction or any other treatments may also be used.
- **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.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation or exercises. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. Cerebrovascular injury or stroke leading to death could occur upon severe injury to arteries of the neck. Nutritional supplementation we recommend may cause energy or chemical imbalances causing injury or death.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and may be even further reduced by screening procedures.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I, _____, have read and fully understand the above statements. I have also had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment plan, and herby give my full consent for chiropractic care.

_____ _____

Signature *Date*

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

Family/Non-Family Release Consent

I, _____, hereby consent to release my child's medical records and files to the following family or non-family members:

Name: **Relationship:**

Reason:

Signature of parent or legal guardian: **Date:**

Witness: Date: