VITA CHIROPRACTIC pediatrics

PEDIATRIC HISTORY FORM

Child's Name_____ Date of Birth ____/____/____ Today's Date:____/____/____ Age_____

Birth Height:_____ Birth Weight:_____ Current Height:_____ Current Weight:_____ Male ☐ Female ☐

Address_____ City_____ State_____ Zip_____

Mother's Name: _____ Mother's Phone #: _____ Date of Birth ____/____/_____

Father's Name: _____ Father's Phone #: _____ Date of Birth ____/____/_____

Pediatrician/Family MD: _____ City & State:_____

Last Visit Date: ____/____/_____ Reason for Visit: _____

Who is responsible for bills/finances? _____Relationship: _____

☐ Other (Please Explain) _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW

Health Concern: (List according to Severity)	**Rate of severity** 0 = no pain 10 = unbearable	**When did this problem start?**	**Have you had the problem before?** If so, when?	**Did this begin with an injury?**	**Are symptoms Constant** (C) **Intermittent** (I)?
First:					
Second:					
Third:					

PURPOSE OF THIS VISIT: Wellness check-Up ☐ Injury or Accident ☐ Other ☐_____

PLEASE EXPLAIN: _____

If your child is experiencing pain/discomfort, please identify where and for how long: _____

_____

1. **When did this problem first begin?** Date: _____/_____/_____ Unknown ☐
   Gradual ☐ Sudden ☐
2. **Have you seen other doctors for these conditions?** Yes ☐ No ☐ If yes, Who & When? _____
3. **Any bowel or bladder problems since this problem began?:** No ☐ Yes ☐
   If yes; Please describe: _____
   a. **Ever experienced this problem before?** No ☐ Yes ☐
      If yes; when: _____ Days _____Weeks _____Months _____Years
4. **What were the results?** FAVORABLE UNFAVORABLE (please explain)
   _____
5. **How is this problem NOW:** Quickly Improving ☐ Slowly Improving ☐ Same ☐ Gradually worsening ☐ On & Off ☐
6. **Please list any medication taken for this problem**: _____
7. **Does your child participate in organized sports?** No ☐ Yes ☐ If yes, Have they ever sustained an injury?
   Please explain: _____
   _____

8. **Has your child ever been in an auto accident?** No ☐ Yes ☐ If yes, Have they ever sustained an injury?
Please explain: _____
_____

HAS YOUR CHILD EVER SUFFERED FROM:

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Bed Wetting	___ Colic	___ Asthma	___ Fall from high chair
___ Migraines	___ Dizziness	___ Reflux	___ Trouble Breathing	___ Fall from Changing Table
___Backaches	___ Fainting	___ Stomach Aches	___ Ruptures/Hernia	___ Fall from Crib
___ Neck Problems	___ Chronic Earaches	___ Poor Appetite	___ ADD/ADHD	___ Fall from Bed or Couch
___ Shoulder Pain	___ Ear Infections	___ Constipation	___ Behavioral Problems	___ Fall off bicycle
___ Arm Problems	___ Seizures/Convulsions	___ Diarrhea	___ Muscle Pains	___ Fall off Swing
___ Leg Problems	___ Heart Trouble	___ Anemia	___ Growing Pains	___ Fall down Stairs
___ Hip Pain	___ Sinus Trouble	___ Hypertension	___ Walking Trouble	___ Fall off Slide
___ Knee Pain	___ Orthopedic Problems	___ Skin Problems	___ Broken Bones	___ Fall off Monkey Bars
___ Foot Pain	___ Recurrent Colds/Flu	___ Sleep Problems	___ Scoliosis	___ Fall off Skateboard/Skates
___ Poor Posture	___ Digestive Disorders	___ Allergies	___ Joint Problems	___ Fall in baby walker

Other(s): _____ _____ _____

Pregnancy Information:

Overall, how was your pregnancy? _____

Any Pregnancy Complications? _____

Did you take any medication during your pregnancy?:_____

Other pertinent information:_____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section

_____

Induced? Yes ☐ No ☐ _____

Medications during delivery?: _____

Other Information: _____

POST BIRTH INFORMATION:

Breast Fed: Yes ☐ No ☐ If yes, how Long?_____ Introduced Solid Foods at _____ months

Food Allergies or Intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 Months_____ Total of Lifetime_____

Present prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

List all surgical operations and years: _____

Has your Child ever been knocked unconscious? Yes ☐ No ☐ Fractured A Bone? Yes ☐ No ☐

If yes to either of the above, please describe:_____

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	**EFFECT:**			
Holding Head up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Tummy Time	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Nursing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Crawling	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing Alone	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking Alone	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other:_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____ _____ _____

PRINT NAME OF PARENT/LEGAL GUARDIAN SIGNATURE DATE

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO VITA CHIROPRACTIC FOR ALL FEES ASSOCIATED WITH CHIROPRACTIC CARE MY CHILD RECEIVES. I AUTHORIZE DR. ZACH NELSON AND ANY AND ALL VITA CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD. ALL RISKS OF CHIROPRACTIC CARE HAVE BEEN EXPLAINED TO ME I HAVE CONVEYED MY UNDERSTANDING OF THESE RISKS TO THE DOCTOR.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY VITA CHIROPRACTIC. UNDER THE TERMS AND CONDITIONS OF MY DIVORCE, SEPARATION, OR OTHER LEGAL AUTHORIZATION, THE CONSENT OF A SPOUSE/FORMER SPOUSE OR OTHER GUARDIAN IS NOT REQUIRED. IF MY AUTHORITY TO SO SELECT AND AUTHORIZE THIS CARE SHOULD CHANGE IN ANY WAY, I WILL IMMEDIATELY NOTIFY VITA CHIROPRACTIC.

_____ _____

PRINT NAME OF GUARDIAN **RELATIONSHIP**

_____ _____

GUARDIAN SIGNATURE **DATE**

_____ _____

DOCTOR/CA SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

GUARDIAN'S SIGNATURE **DATE**