LIFE FAMILY CHIROPRACTIC

CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Birth Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mother: _____ **Phone:** _____

Father: _____ **Phone:** _____

HEALTH HISTORY - FOR INFANTS & NEWBORNS ONLY (Under 2yoa)

PRENATAL HISTORY

Name of Previous Chiropractor: _____

Birth Weight: _____ **Birth Length:** _____ **Full Term?** ❑ No ❑ Yes_ *(Describe):* _____

Complications during pregnancy? ❑No ❑ Yes_ *(Describe):* _____

Medications during pregnancy or delivery? ❑ No ❑ Yes_ *(List):* _____

Cigarette/Alcohol/Drugs during pregnancy? ❑No ❑ Yes_ *(List):* _____

Birth Interventions? ❑ No ❑ Forceps ❑ Vacuum ❑ Caesarian ❑Other _____

FEEDING HISTORY

Breast fed? ❑No ❑ Yes *(How Long?)* _____ **Formula fed?** ❑ No ❑ Yes *(How Long?)* _____

Introduced to cereal at _____ months old. **Introduced to solids at _____ months old.**

Food/Juice allergies or intolerances? ❑No ❑Yes_ *(Describe):* _____

DEVELOPMENTAL HISTORY

Sleep *(Hours per Night?)* _____ **Problems Sleeping?** *(Describe)* _____

HAS YOUR CHILD EVER SUFFERED FROM: All ages (*Check all that apply*)

Pediatric
- ❑ ADHD
- ❑ Allergies/Asthma
- ❑ Autism
- ❑ Back/Neck Pain
- ❑ Bed Wetting
- ❑ Behavioral issues
- ❑ Chronic Earaches
- ❑ Colic
- ❑ Constipation
- ❑ Growing Pains
- ❑ Nightmares
- ❑ Reflux
- ❑ *None in this Category*

Childhood Diseases
- ❑ Chicken Pox: Age____
- ❑ Measles: Age____
- ❑ Meningitis: Age____
- ❑ Mumps: Age____
- ❑ Rubella: Age____
- ❑ Tuberculosis: Age____
- ❑ Whooping Cough: Age____
- ❑ Other: _____ Age____
- ❑ *None in this Category*

Surgeries: ❑ Ear Tubes left / right / both
❑ Tonsils / Adenoids
❑ Other: _____

Has your Child been Vaccinated? ❑ No ❑ Yes

Adverse Reactions? ❑ No ❑ Yes Describe: _____

_____

_____

Would you like more information about alternatives to vaccines and/or the side effects of vaccines? ❑ Yes ❑ No

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

_____

_____

_____

Past Medications: _____

_____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Describe Major Complaint for seeking care today: _____Onset of Symptoms: _____
Describe how it began:_____
_____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: _____

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:*_____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

How does this condition affect your daily activities? *(Describe)* _____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: _____ Where? _____

Surgery? *(Describe)*_____

Medications? OTC / Prescriptions *(Describe)*_____

Diagnostic testing? X-rays / MRI / CT / Other:_____When and Where? _____

❑ Acupuncture ❑ Massage ❑ Other: _____

Describe any Secondary Complaints: _____

Any family history that might be relevant: _____

Is there anything else you would like the doctor to know? _____

Who may we thank for referring you to our office? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide _____ (Minor / Patient's Name) with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of the clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient / Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

LIFE FAMILY CHIROPRACTIC

Consent for Treatment of Minor Child

Today's Date: _____

Patient Name: _____

Patient DOB: _____

I hereby request and authorize Dr. Adcock and whomever he may designate, to perform diagnostic tests and render chiropractic care to the minor child named above.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____ DATE: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons per year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____