Pediatric Health Record

New Patient ☐
Reactivate ☐

Name: ______________________ Parent's Home Phone: ______________
Street Address / P.O. Box ______________________ Parent's Mobile Phone: ______________
City / State / Zip: ______________________ Parent's Work Phone: ______________
Social Security Number: ______________________ Child's Birthdate: ______________
Mom's Name: ______________________ Insured's Employer: ______________
Dad's Name: ______________________ Family Email: ______________
Names / Ages of Other Children at Home: ______________________
Who is Their Family Medical Doctor? ______________ Facility / City: ______________
How Were You Referred? ☐My M.D. ☐Ins. Plan ☐Another Person: ______________ Other: ______________

History of Present Illness / Injury

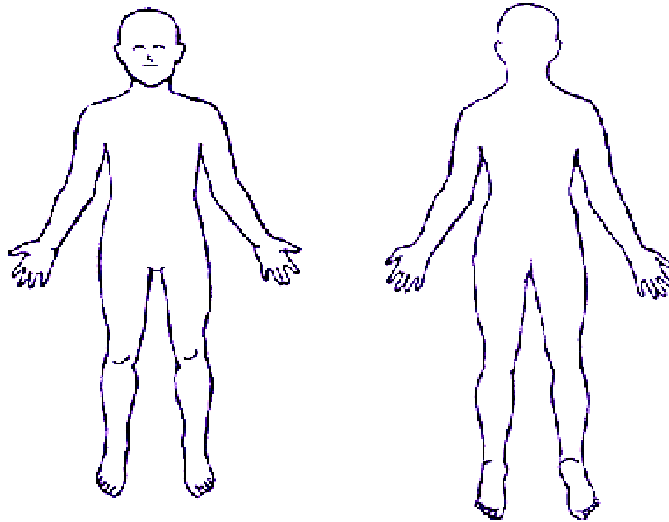
Chief Complaint(s)

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Circle the number on the ruler below that corresponds with the degree of discomfort. If there is more than one area of discomfort, rate it on a scale of 0 to 100 next to each area, with 0 being no pain and 100 being intolerable pain.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain

Please Complete:
_____ Constant
_____ Come & Go
_____ Getting Better
_____ Getting Worse
_____ Staying Same

Better:		Worse:
_____	AM	_____
_____	Mid-Day	_____
_____	PM	_____



No Pain **Pain Scale:** **Intolerable**

What Makes the Condition Better?

Head / Neck ______________________
Mid Back ______________________
Low Back ______________________
Shoulder, Arm, Hand ______________________
Hip, Leg, Foot ______________________
Other ______________________

What Makes the Condition Worse?

Head / Neck ______________________
Mid Back ______________________
Low Back ______________________
Shoulder, Arm, Hand ______________________
Hip, Leg, Foot ______________________
Other ______________________

Describe Specific Symptom(s) or Concern(s): ______________________
How Did It Begin? ______________________ When Did It Start? ______________
What Have You Tried So Far to Remedy the Problem(s): ______________________

YES NO
☐ ☐ Any Recent Loss of Appetite or Change in Eating Habits? How? ______________
☐ ☐ Any Recent Change in Bathroom Habits? How? ______________
☐ ☐ Any Change in Sleeping Habits? How Many Times Does It Wake Them Up? ______________
☐ ☐ Do They Sleep with a Pillow? How Many? ______________ Where are They Placed? ______________
♦What Positions Do They Sleep In? ______________ How Old is Their Mattress? ______________

♦LEVEL OF HISTORY OF PRESENT ILLNESS / INJURY: ☐ BRIEF ☐ EXTENDED

♦NATURE OF PRESENTING PROBLEM: ☐ MINIMAL ☐ SELF LIMITED ☐ LOW SEVERITY ☐ MODERATE SEVERITY ☐ HIGH SEVERITY

PAST MEDICAL HISTORY

HOW MANY TIMES HAS YOUR CHILD HAD THE CONDITION THAT THEY ARE SEEING US FOR TODAY? ☐ NEVER ☐ 1-3 TIMES ☐ 4 OR MORE TIMES

HAS YOUR CHILD SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS NOW OR IN THE PAST?

☐ ADD/ADHD ☐ ASTHMA ☐ AUTISM ☐ BACK PAIN ☐ BED-WETTING ☐ COLIC ☐ EAR INFECTIONS
☐ FREQUENT COLDS ☐ SCOLIOSIS ☐ GROWING PAINS ☐ HEADACHES ☐ TONSIL PROBLEMS ☐ SEIZURES ☐ STOMACH PAINS
☐ FREQUENT FALLS ☐ CRYING SPELLS ☐ REFUSAL TO EAT ☐ ALLERGIES ☐ SKIN RASHES ☐ LEARNING DIFFICULTIES

YES NO

☐ ☐ **DOES YOUR CHILD SUFFER FROM ANY OTHER HEALTH CONDITION(S)?** (DIABETES, CANCER, OTHERS) IF YES, PLEASE EXPLAIN: ____

☐ ☐ **HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE?**

- ♦ WHEN WAS THE LAST TIME THEY WERE SEEN? ____ WHICH DR.? ____
- ♦ FOR WHAT PROBLEM(S)? ____ WERE THEY HELPED? ____
- ♦ HOW OFTEN WERE THEY BEING SEEN? ____ WHY DID YOU LEAVE? ____
- ♦ LIST ANY OTHER CHIROPRACTORS YOUR CHILD HAS SEEN IN THE PAST: (USE MORE PAPER AS NEEDED.)

DATE	DR. NAME	CONDITION(S)	WHY DID YOU LEAVE?

☐ ☐ **HAS YOUR CHILD EVER SEEN A MEDICAL DOCTOR FOR THIS CONDITION?** (USE MORE PAPER AS NEEDED.)

DATE	DR. NAME	CONDITION(S)	RESULTS
			☐ COMPLETE RECOVERY ☐ COMPLICATIONS
			☐ COMPLETE RECOVERY ☐ COMPLICATIONS

☐ ☐ **DO YOUR CHILD HAVE ANY ALLERGIES?** IF SO, TO WHAT? ____

☐ ☐ **LIST ANY PRESCRIPTION DRUGS, OVER THE COUNTER DRUGS, VITAMINS, AND/OR SUPPLEMENTS:** (USE MORE PAPER AS NEEDED.)

PRODUCT / DRUG	REASON(S)	FREQUENCY	DOSAGE	HELPING?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

☐ ☐ **DESCRIBE ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, AND/OR SURGERIES:**

DATE	DR. NAME	CONDITION(S)	RESULTS
			☐ COMPLETE RECOVERY ☐ COMPLICATIONS
			☐ COMPLETE RECOVERY ☐ COMPLICATIONS

☐ ☐ HAVE THEY EVER HAD X-RAYS? WHEN? ____ WHAT BODY PARTS? ____

☐ ☐ DOES YOUR CHILD TRY TO "CRACK" THEIR OWN NECK AND/OR BACK? EXPLAIN: ____

BIRTH & REARING HISTORY

WAS YOUR CHILD'S BIRTH: ☐ ON TIME ☐ EARLY ☐ LATE EXPLAIN: ____

WAS THE CHILD'S DELIVERY: ☐ VAGINAL ☐ CESAREAN (C-SECTION) HOW LONG WAS LABOR? ____

WAS THE CHILD BORN: ☐ AT HOME ☐ IN HOSPITAL ☐ WHO WAS YOUR MIDWIFE / DOCTOR? ____

YES NO

☐ ☐ WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED? ____

☐ ☐ WAS THERE MORE THAN ONE FETUS? IF YES, EXPLAIN: ____

☐ ☐ DID THE MOTHER USE ANY ALCOHOL OR SMOKE DURING PREGNANCY? IF SO, HOW MUCH? ____

☐ ☐ IS/WAS YOUR CHILD VACCINATED? IF YES, DESCRIBE ANY ADVERSE REACTIONS: ____

☐ ☐ IS/WAS YOUR CHILD BREASTFED? IF YES, DESCRIBE ANY DIFFICULTIES: ____

☐ ☐ DID/DOES YOUR CHILD USE FORMULA? IF YES, DESCRIBE ANY DIFFICULTIES/ALLERGIES: ____

FAMILY HEALTH HISTORY

HEALTH STATUS OF FAMILY MEMBERS. (LIST ANY CURRENT OR PAST HEALTH CONDITIONS. OR IF DECEASED, AT WHAT AGE AND FROM WHAT?)

MOTHER: ______________________________

FATHER: ______________________________

SISTER(S): ______________________________ HOW MANY? __________

BROTHER(S): ______________________________ HOW MANY? __________

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS NOW OR IN THE PAST? (PLEASE MARK **Y** FOR YES OR **N** FOR NO IN EACH OF THE FOLLOWING:)

1. ____ **EYES** (GLASSES, CONTACTS, PINK EYE, GLAUCOMA, ETC.)
2. ____ **EARS, MOUTH, NOSE, THROAT** (EAR INFECTIONS, SINUS, ETC.)
3. ____ **CARDIOVASCULAR** (HEART, MURMUR, IRREGULAR BEAT, ETC.)
4. ____ **RESPIRATORY** (LUNGS, BREATHING, ASTHMA, ETC.)
5. ____ **NEUROLOGICAL** (NERVE ISSUES, WEAKNESS, NUMBNESS, ETC.)
6. ____ **ENDOCRINE** (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)
7. ____ **GASTRO-INTESTINAL** (ACID REFLUX, COLIC, CONSTIPATION, I.B.S., ETC.)
8. ____ **GENITO-URINARY** (BED WETTING, KIDNEYS, BLADDER, ETC.)
9. ____ **MUSCULOSKELETAL** (BREAKS, ARTHRITIS, SCOLIOSIS, ETC.)
10. ____ **SKIN** (RASHES, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)
11. ____ **PSYCHIATRIC** (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)
12. ____ **OTHERS**: ______________________________

PLEASE DESCRIBE IN MORE DETAIL: ______________________________

NOTES:

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT SIGNATURE: ______________________________ DATE: ______________

GUARDIAN SIGNATURE: ______________________________ DATE: ______________

D.C. / C.A. SIGNATURE: ______________________________ DATE: ______________

ADDITIONAL COMMENTS:

♦ **LEVEL OF PAST MEDICAL / SOCIAL / FAMILY HISTORY:**

☐ **N/A** ☐ **PERTINENT (1 OF THE ABOVE HISTORIES)** ☐ **COMPLETE (2 OR 3 OF THE ABOVE HISTORIES)**

♦ **LEVEL OF SYSTEM REVIEW:**

☐ **N/A** ☐ **PROBLEM PERTINENT (1 ABOVE SYSTEM)** ☐ **EXTENDED (2 TO 9 ABOVE SYSTEMS)** ☐ **COMPLETE (10+ ABOVE SYSTEMS)**

♦ **LEVEL OF OVERALL HISTORY:**

☐ **PROBLEM FOCUSED** ☐ **EXPANDED PROBLEM FOCUSED** ☐ **DETAILED** ☐ **COMPREHENSIVE**

INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFORE, IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULLY INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTIONS, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE – STROKE IS THE MOST SERIOUS POTENTIAL COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN IT OCCURS, IT MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS, DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHIN THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT BETWEEN 1 PER 400,000 TREATMENTS TO 1 PER 5.8 MILLION TREATMENTS. USING DATA FROM TWO OF THE LARGEST CHIROPRACTIC INSURERS, THE RISK OF SERIOUS ARTERIAL STROKE SYNDROMES IS SHOW TO BE LESS THAN 1 IN 2 MILLION TO 1 IN 3.8-5.8 MILLION CERVICAL MANIPULATIONS. THE MOST COMMON TYPE OF VASCULAR LESION WITH THIS ASSOCIATION IS A DISSECTION OF THE VERTEBRAL ARTERY. (*CURRENT CONCEPTS: SPINAL MANIPULATION AND CERVICAL ARTERIAL INCIDENTS, 2005.*) **A 2008 STUDY IN SPINE JOURNAL STATES: "WE FOUND NO EVIDENCE OF EXCESS RISK OF VBA STROKE ASSOCIATED WITH CHIROPRACTIC CARE COMPARED TO PRIMARY CARE." THEREFORE, THE RISK IS THE SAME NO MATTER WHOM YOU CHOOSE TO SEE.**

SORENESS – CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST-TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IT IS GENERALLY NOT DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY – OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY – MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS TAKING PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES DEEMED "AT-RISK." TREATMENT IS PERFORMED CAREFULLY AND GENTLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS – HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS – THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE INDEED RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS OUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL BEST ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED ______________________

TODAY'S DATE ______________________

PATIENT'S SIGNATURE ______________________

PARENT OR GUARDIAN'S SIGNATURE FOR MINOR ______________________

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