Life Chiropractic
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# PEDIATRIC FORM

## Personal Information

Full Name: ______________________________ Date: ____________

Preferred Name: ______________________________

Age: ______ Gender: ______ Wt: ________ Ht: ________ Date of Birth: ____________

Address: ______________________ City: __________ Zip: __________

Parent's Name: ______________________ Phone: ____________

Parent Email: ______________________________

Pediatrician: ______________________ Phone: ____________

Siblings Names: ______________________ Age: ________ Gender: ______

______________________ Age: ________ Gender: ______

______________________ Age: ________ Gender: ______

How did you hear about our office? ______________________________

## Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out this form on their own.

What is/are the health condition(s) are you concerned with today?

Major concern: ______________________________

Onset: ______________________________

Is this condition: □ getting worse □ constant □ comes and goes

Is this condition interfering with: □ school □ sleep □ daily routine

Have you had this or similar conditions in the past? ____________________

Have you been treated by a medical doctor for this condition? ____________________

If so, where? ______________________ Results? ____________________

Have you ever had Chiropractic Care before? ____________________

If so whom? ______________________ Results? ____________________

# Health History

Please explain any difficulties during pregnancy or labor? ________________________________________

________________________________________________________________________________

**The following occurred at delivery:**

| | | |
|---|---|---|
| Vaginal Delivery | Planned C-Section | Emergency C-Section |
| Face Presentation | Forceps/Vacuum | Induced labor/Pitocin |
| Breech Presentation | Anesthesia Used | Neonatal Intensive care |

During Infancy my child was: Breast Fed ___________ months Bottle Fed ___________ months

My child is on the following vaccine schedule: ◻ standard ◻ alternative ◻ none

**Personal Health History – Has this child ever suffered from:**

| | | |
|---|---|---|
| ◻ Major falls/injuries/fractures | ◻ Respiratory problems | ◻ Ear Infections |
| ◻ Allergy/Asthma | ◻ Bedwetting | ◻ Digestive Problems |
| ◻ Hyperactivity | ◻ Hospitalization | ◻ Extremity problems |
| ◻ Anxiety Disorder | ◻ Seizures | ◻ Back pain |
| ◻ Recurrent antibiotic use | ◻ Behavior problems | ◻ Poor appetite |
| ◻ Dizziness/Fainting | ◻ Heart trouble | ◻ Diabetes |
| ◻ Anemia/Blood Disorders | ◻ Tuberculosis | ◻ High Blood Pressure |
| ◻ Arthritis | ◻ Headaches | ◻ Growing Pains |
| ◻ Colic | ◻ Sinus Trouble | |

My child has met all developmental milestones: Yes/No

Please list any other serious medical condition(s): ________________________________________

Allergies to foods or medications: ________________________________________

Surgeries: ________________________________________

Past Serious Accidents: ________________________________________

Please answer the following as completely as possible. Does your child:

Take supplements or vitamins? ________________________________________

Take Prescription Drugs? Please List: ________________________________________

Follow a special diet? ________________________________________

Carry a backpack (what style)? ________________________________________

Play sports (which ones)? ________________________________________

Play on Computer/Video Games (amt/day)? ________________________________________

How would you rate your child's diet?

□ Well-balanced □ Average □ High amounts of sugar & processed foods

Does your child consume artificial sweeteners? Yes No Fluoridated water? Yes No

Number of hours your child sleeps? _______/ day Quality: □ Good □ Fair □ Poor

Family Health History: Please check below if someone in the child's immediate family has had the following. Please write how they are related to the child.

□ Back Problems: ____________________ □ Headaches ____________________
□ High Blood Pressure: ____________________ □ Ulcer/Digestive Problem ____________________
□ Thyroid Disorder: ____________________ □ Heart Disease: ____________________
□ Stroke: ____________________ □ Arthritis: ____________________
□ Diabetes: ____________________ □ Cancer: ____________________
□ Osteoporosis: ____________________ □ Mental Illness: ____________________

## Wellness Profile:

Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Circle as many goals as you wish.

More energy
Easier breathing
Improved coordination
Better sports performance
Greater resistance to disease
Better sleep
More balanced posture
Reduce medications
Enhanced emotional well-being
Relief care for current symptom
Freedom from pain
Improve nutrition
Improve overall health
Better concentration
Other: ____________

## Authorization to Treat a Minor

I, ______________________________ the undersigning parent/person having legal custody/guardianship of ______________________________, a minor, do hereby authorize, request and direct Bruce D. Stevens, D.C. and whomever he/she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

Patient Name: ____________________ DOB: ____________SSN:____________

Print Name and Relationship of Adult Signing:______________________________

Parent/Legal Guardian Signature:______________________________

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 or an instrument 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, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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 or Guardian: __________________________ Signature: ___________________________ Date: _____________

Witness Name: ______________________________Signature: ___________________________ Date: _____________