LIFE CHIROPRACTIC

PEDIATRIC NEW PATIENT 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

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

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

Primary 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?_____

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

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

My child is on the following vaccine schedule (optional): ☐ standard ☐ alternative ☐ none

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: _____

Carry a backpack (what style)? _____

Play sports (which ones)? _____

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

Typical Daily Diet:_____

_____

_____

Does your child consume artificial sweeteners? ☐ 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 and indicate 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	☐ Better sleep	☐ Freedom from pain
☐ Easier breathing	☐ More balanced posture	☐ Improve nutrition
☐ Improved coordination	☐ Reduce medications	☐ Improve overall health
☐ Better sports performance	☐ Enhanced emotional well-being	☐ Better concentration
☐ Greater resistance to disease	☐ Relief care for current symptom	Other: _____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Morgan D. Hurd, 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: _____

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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, 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 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:**_____

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