# Pediatric History Form

Today's Date ___/____/____

## PATIENT DEMOGRAPHICS

Child's Name _____ Date of Birth ____/_____/_____ Age:_____

Birth Height: _____ Birth Weight _____ Current Height:_____ Current Weight: _____

Address _____ City_____ State: _____ Zip Code _____

Mother's Name: _____ Phone # _____

Father's name: _____ Phone # _____

Pediatrician/Family MD _____ City & State _____

Last Visit: ___/___/_____ Reason for Visit: _____

Who is responsible for this bill? _____

## Child's Current Problem:

Purpose of this visit: _____ Wellness _____ Injury or Accident _____ Other

When did the problem first begin? Date ___/___/____ How long has it been going on? _____

Is it getting better or worse? _____ Does anything make it better? _____

worse?_____ Ever had this problem before? ____ Yes ____ No if yes, When? _____

Have you seen other doctors for this problem? YES or NO If yes who? _____

How long ago? _____ What were the results of past treatment? _____

Please list any medications given for this problem: _____

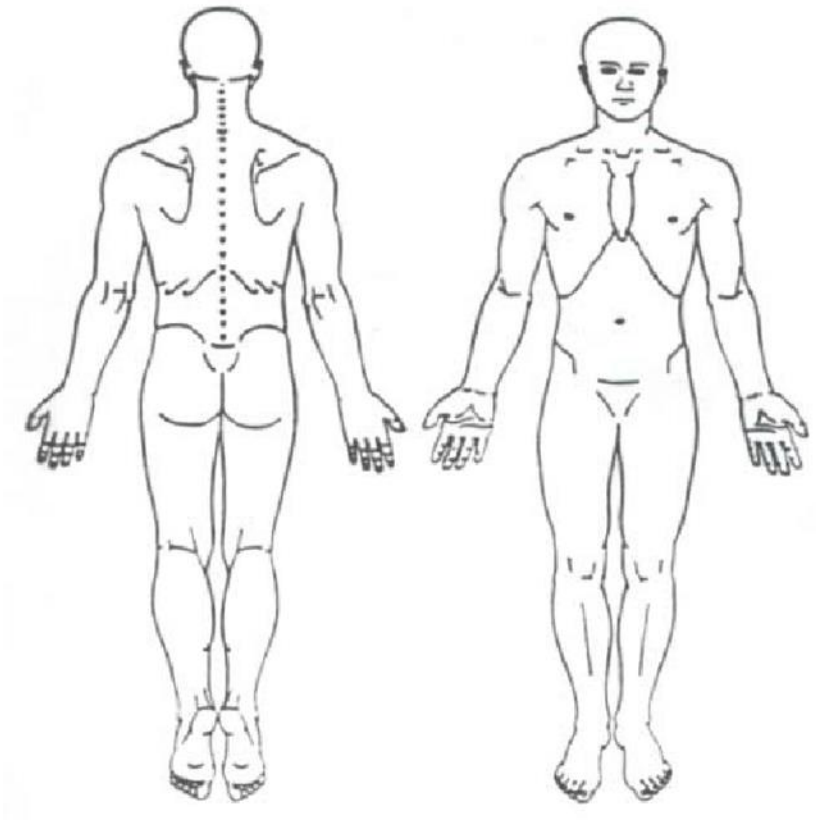
Has your child ever sustained an injury playing organized sports? _____ if yes; please explain

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain

_____

**Show us where it hurts**



| | |
|---|---|
| **R**= **R**adiating | **B**= **B**urning |
| **D**= **D**ull | **A**= **A**ching |
| **N**= **N**umbness | **S**= **S**harp/**S**tabbing |
| **T**= **T**ingling | |

**HAS YOUR CHILD EVER SUFFERED FROM**: Check if YES

| | | | |
|---|---|---|---|
| __ Headaches | __ Orthopedic Problems | __ Digestive Disorders | __ Behavioral Problems |
| __ Dizziness | __ Neck Problems | __ Poor Appetite | __ ADD/ADHD |
| __ Fainting | __ Arm Problems | __ Stomach Ache | __ Ruptures/Hernia |
| __ Seizures | __ Leg Problems | __ Reflux | __ Muscle Pain |
| __ Heart Trouble | __ Joint Problems | __ Constipation | __ Growing Pains |
| __ Chronic Earaches | __ Back Aches | __ Diarrhea | __ Allergies to _____ |
| __ Sinus Trouble | __ Poor Posture | __ Hypertension | __ Asthma |
| __ Scoliosis | __ Anemia | __ Walking Trouble | __ Bed Wetting |
| __ Colic | __ Broken Bones | __Sleeping Problems | __ Fall in baby walker |
| __ Fall from crib | __ Fall from bed or couch | __ Fall off swing | __ Fall off bicycle |
| __ Fall from high chair | __ Fall down stairs | __Fall off skateboard/skates | __Other _____ |

# 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, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. 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.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 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 visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

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:_____

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the line, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

__ The first day of my last menstrual cycle was on ___/___/____

__ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____

Printed Name

_____ ___/____/_____

Patient or Authorized person's Signature Date

_____ ___/ ___/ _____

Witness Signature Date