SPINE AND SPORT
FAMILY CHIROPRACTIC

PEDIATRIC CHIROPRACTIC INTAKE FORM

Name of Child _____ Date _____

Date of Birth _____ Gender: Male ◯ Female ◯

Name of Parent/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Text Reminders: Yes _____ No _____

Siblings, Name & Ages _____

Reason for today's visit? _____

Who can we thank for your referral? _____

Date of last pediatrician appointment/reason? _____

Any health concerns? _____

Has your child undergone care for any conditions? (please list medications) _____

_____

Birth Location: Home Birth ◯ Birth Center ◯ Hospital ◯ Birth Provider: Midwife ◯ OBGYN ◯

Duration of pregnancy: _____weeks Induced labor ◯ C-Section ◯ Vacuum ◯ Forceps ◯

Birth Weight: _____ Length: _____ Duration of Labor/active labor: _____ APGAR: _____

Any medications during labor/delivery: _____ Is so, what kind: _____

Any complications with birth? _____ If yes, please describe: _____

Was baby alert and responsive within 12 hours of birth? _____ If no, please explain: _____

Do sleeping patterns seem normal to you? _____ If no, please explain: _____

How many wet diapers in a day? _____ How many dirty diapers in a day? _____

What is baby's diet like? (Breastfeeding times, oz of milk, formula, solids, etc.) _____

_____

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SINCE THE HEALTH OF THE NERVOUS SYSTEM CAN BE AFFECTED BY MANY TYPES OF STRESSORS, THE FOLLOWING INFORMATION IS <u>VERY IMPORTANT</u>.

CHEMICAL STRESSORS (Childs age may not apply to parts of this section)

Was baby breast fed? Yes ◯ No ◯ For how long? _____

Was formula ever introduced? Yes ◯ No ◯ What age/type of formula? _____

Was there introduction of cow's milk? Yes ◯ No ◯ What age? _____

Food/Juice intolerance? Yes ◯ No ◯ If Yes, what type? _____

Did mother smoke during pregnancy? Yes ◯ No ◯ Did mother drink alcohol? Yes ◯ No ◯

Any illness of mother during pregnancy? Yes ◯ No ◯ Any drugs taken during pregnancy? Yes ◯ No ◯

Any invasive procedures (amniocentesis, CVS?) Yes ◯ No ◯

Was baby vaccinated at birth Yes ◯ No ◯ If yes, which ones? _____

Any reactions to vaccines? Yes ◯ No ◯ If yes, what kind? _____

Any antibiotics since birth? Yes ◯ No ◯ If yes, what kind? _____

PSYCHOSOCIAL STRESSORS (Childs age may not apply to parts of this section)

Any difficulties with nursing? Yes ◯ No ◯ If yes, what kind? _____

Any behavioral problems? Yes ◯ No ◯ If yes, what kind? _____

Any night terrors, sleepwalking, bed wetting? Yes ◯ No ◯ Explain: _____

TRAUMATIC STRESSORS (Childs age may not apply to parts of this section)

Any traumas during pregnancy (falls/accidents) Yes ◯ No ◯ If yes, what kind? _____

Any birth trauma evidence? (bruises, odd shaped head, stuck in birth canal, excessively long birth, respiratory depression, cord around neck, other?) Yes ◯ No ◯ If yes, what kind? _____

Any falls from couches, bed, changing tables? Yes ◯ No ◯ If yes, what kind? _____

Any Hospitalizations? Yes ◯ No ◯ If yes, please explain: _____

Any surgeries? Yes ◯ No ◯ If yes, please explain: _____

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Sports played and years began? _____ Hours per week: _____

Weight of school backpack? _____

Has your child ever seen a Chiropractor? Yes ◯ No ◯ Name of Chiropractor _____

MILESTONES (Circle all those that apply please)

1-3 MONTHS:

	Supports head and upper body when on stomach?		Stretches out legs and kicks when on back or stomach?
	Opens and shuts hands?		Grabs and shakes toys?
	Follows moving objects with eyes?		Turns head to sound of stimulus?
	Makes cooing sounds?		Smiles at familiar faces?

4-7 MONTHS:

	Rolls over both stomach to back & back to stomach?		Sits up with/without support?
	Reaches for objects?		Transfers objects from hand to hand?
	Supports whole weight standing?		Explores objects with hands and mouth?
	Laughs?		Babbles consonants?

8-12 MONTHS:

	Gets in and out of sitting position independently?		Gets on hands and knees position to crawl?
	Pulls self up to standing/walks along furniture?		Holding spoon or book by themselves?
	Says “mama” and “dada” referring to parent?		

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Authorization and Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment and healthcare operations, and coordination of care. We want you to know how your patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

Name_____ Relationship_____

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient: _____ Date:_____

Guardian's Signature Authorizing Release: _____ Date: _____

Informed Consent

The Doctor will use their hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, (also known as Oculosympathetic Palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complain following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant.

IF YOU ARE PREGNANT, OR THINK YOU MAY BE PREGNANT YOU SHOULD TELL ME OR MY OFFICE STAFF AT THE TIME OF YOUR EXAM.

Printed Patient Name:_____ Date: _____

Patient Signature: _____

Signature of Parent or Guardian (if minor): _____