Pediatric History Form

Patient Name_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Work Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition **Y☐N☐** Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms:
Please check any problems your child has had within the last 6 months on the list below:

ADHD ☐	Asthma ☐	Growing pains ☐	Diabetes ☐
Hyperactivity ☐	Allergies ☐	Joint Pain ☐	Unusual Moles ☐
Autism ☐	Runny Nose ☐	Neck Pain ☐	Hernias ☐
Behavior Problems ☐	Sinus Trouble ☐	Back Pain ☐	Anemia ☐
Poor Memory ☐	Frequent Colds ☐	Chest Pain ☐	Rheumatic Fever ☐
Bed Wetting ☐	Itchy Eyes ☐	Leg/Hip Pain ☐	Tuberculosis ☐
Insomnia ☐	Cough/Wheeze ☐	Knee/Foot Pain ☐	**Others…**
Nightmares ☐	Rashes ☐	Arm/Elbow Pain ☐	
Poor Appetite ☐	Ear Aches/Infections ☐	Sprains/Strains ☐	
Gassy/Bloated ☐	Headaches ☐	Scoliosis ☐	
Stomach Aches ☐	Dizziness ☐	Arthritis ☐	
Constipation ☐	Fainting ☐	Blood disorders ☐	
Diarrhea ☐	Seizures/Convulsions ☐	Heart Condition ☐	
Pain Urinating ☐	Paralysis ☐	Hypertension ☐	

Health History:

Name of Pediatrician:_____ Date of last visit_____

Reason for visit:_____

Medications and conditions being treated:_____
_____

Has your child ever taken antibiotics? **Y☐N☐** Condition treated:_____

Date of last antibiotic usage: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) **Y☐N☐**

- If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
  _____
- Has your child ever been involved in a car accident? Y/N Date & Injuries _____
  _____
- Please describe any other traumas not mentioned above:_____
  _____

Have you noted any sudden behavioral changes in your child? Y/N _____

Prior surgery: **Y☐N☐** Type and Date:_____ Menarche: **Y☐N☐** Age:_____

Prenatal History

Location of Birth: ☐Home ☐Birthing Center ☐ Hospital ☐ Unknown

Complications during pregnancy: **Y☐N☐** Please Describe_____

Ultrasounds during pregnancy: **Y☐N☐** Number/Reason: _____

Drugs used during pregnancy/delivery (Over the counter, Prescription, Recreational) **Y☐N☐** Please describe: _____

Cigarette / Alcohol use during pregnancy: **Y☐N☐** How many drink/packs per week?_____

Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____
Complications during delivery: Y/N List: _____
Genetic disorders or disabilities: Y/N List: _____
Birth weight_____

Feeding history

Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Lift head _____ Roll over _____Crawl _____
Sit alone _____ Stand alone _____ Walk alone _____ Say words _____

Childhood Diseases
O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___
O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:

☐ CDC Schedule

☐ Modified schedule

☐ Not vaccinated

Adverse Reactions to Any Vaccine? Y/N List: _____

Informed Consent to Treat

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any healthcare procedure, there are certain complications which may arise during chiropractic care. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulations have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel stiffness or soreness in the first few days of treatment. The Doctor will make every effort to screen for any possible contraindications to care; however if you have a condition that would not otherwise come to the Doctor's attention it is your responsibility to inform the Doctor.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. Stroke and/or arterial dissection cause by chiropractic manipulation of the neck has been subject to ongoing research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk for arterial stroke.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Consent to Treatment (Minor)

I hereby request and authorize Roy Farris, DC of Healthy Foundations Spinal Care, LLC to perform diagnostic adjustments and other treatment to my minor son/daughter: _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As Of this date, I have legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and condition of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or any other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read or had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient:

_____	_____	_____
Printed Name	**Signature**	**Date**

Parent/Guardian (If a Minor):

_____	_____	_____
Printed Name	**Signature**	**Date**

ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Healthy Foundations Spinal Care Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Healthy Foundations Spinal Care and how I may obtain access to and control this information.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date