Pediatric Intake

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address: _____

City/State/Zip: _____

Birth Date: _____ Age: _____ Sex: M F

# of Siblings: _____ Siblings Names & Ages: _____

_____

Parent's Names: _____

Best Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Parent's Email: _____

Who can we thank for referring you or how did you hear about our office? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Align Family Chiropractic? _____

_____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Has your child seen any other providers for this condition? (List all that apply)

_____

Has your child seen a chiropractor before? YES NO

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for change? (if applicable) _____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you're child were to complete or accomplish it, would have the greatest impact on his/her life? _____

HEALTH CONCERNS

- □ Anxiety/Depression
- □ Constipation/Diarrhea
- □ Nausea/Vomiting
- □ Diabetes
- □ Bed Wetting
- □ Overweight
- □ Frequent Sickness
- □ ADD/ADHD
- □ Detachment/Distant
- □ Irritability/Nervous
- □ Fatigue/Sleep Issues
- □ Asthma/Chronic Bronchitis
- □ Colic/Acid Reflux
- □ Back/Neck Pain/Stiffness
- □ Difficulty Gaining Weight
- □ Ear or Other Infections
- □ Headaches
- □ Learning Disorders
- □ Sinus Troubles/Allergies
- □ Autism/Asperger's
- □ Other _____
- □ Other _____

Explain any boxes checked above:

_____

_____

_____

_____

_____

_____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____

_____

MEDICATIONS

- □ Anxiety/Depression
- □ Asthma
- □ Pain Narcotics
- □ Antibiotics
- □ Migraine/Headache
- □ Acid Reflux
- □ ADD/ADHD
- □ Diabetes
- □ Other _____
- □ Other _____
- □ Other _____

Explain any boxes checked above: _____

_____

_____

_____

DID YOU KNOW…

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue/Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain/Numbness in Legs
Reproductive Problems

VITAMINS/SUPPLEMENTS

- □ Multivitamin
- □ Vitamin D3
- □ _____
- □ _____
- □ Fish Oil/Omega-3
- □ Probiotics
- □ _____
- □ _____

Explain any boxes checked above:

_____

_____

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: _____
Did any of the following happen during delivery:
-C-section delivery -Doctor pulled or twisted baby -Anesthesia -Labor was induced
-Forceps/vacuum extraction -Premature delivery -Special medical procedures/tests
Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

_____

Did you experience any illness while pregnant? Y N If yes, explain: _____
Do you have any physical disabilities? Y N If yes, explain: _____
Birth weight: _____ Birth Length: _____ APGAR scores (if remembered): _____
Ultrasound used during pregnancy? Y N Number of times: _____
Did you breastfeed the baby? Y N If yes, how long: _____
Did you formula-feed the baby? Y N If yes, how long: _____
At what age did you introduce: Solids _____ Cow's milk: _____

LIFESTYLE HABITS:

Does your child exercise daily? Y N How much? _____
Does your child drink soda? Y N How much/often? _____
Does your child have a positive self-esteem or self-image? _____
Does your child watch more than an hour of TV per day? Y N How much? _____
Does your child eat balanced meals? Y N
Does your child experience prolonged sadness? Y N Explain: _____
Does your child have difficulty sleeping? Y N Explain: _____
Does your child play video games? Y N How much? _____

CURRENT HEALTH STATUS:

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Y N
Explain: _____
Has your child ever been hospitalized or had surgery? Y N Explain: _____
Does your child have difficulty interacting with others? Y N Explain: _____
Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Y N
Explain: _____
Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc? Y N Please list: _____
Are you aware of any food allergies or intolerance? Y N Explain: _____
Has your child received all recommended vaccinations? Y N Explain: _____
Please rate stress levels on a scale of 1-10 (10 being highest)
School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR:

I, (Parent/Guardian) _____, give Align Family Chiropractic permission to examine, x-ray (if necessary), and treat _____.
Parent/Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointment as scheduled or call the office within 12 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- If more than two scheduled appointments are missed without a 12-hour notice, you may be subject to a cancellation fee.
- With the exception to Medicare, we are out of network with all insurance companies. It is your responsibility to pay in full after each visit.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special arrangements, we will do everything possible to meet your financial needs.

Patient Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

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 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.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

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 circumstances. 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 Signature: _____ Date: _____
Parent or Guardian: _____ Date: _____
Witness Signature: _____ Date: _____