Pediatric Registration Form

Patient Name: ____________________________ S.S.#: _____-____-_____ Today's Date: ___/___/_______

Address: ________________________________ City: _________________ State: ______ Zip: ___________

Home Phone: __________________ Work Phone: __________________ Cell Phone: ___________________

Birth Date: ___/___/________ Sex: M / F Weight: _______ Height: _______ Referred by: _____________

Name of Parents / Guardians: ____

Check any of the following conditions your child has suffered from during the past six months:

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic Colds	□ Headaches
□ Asthma/Allergies	□ Acid Reflux	□ ADD/ADHD	□ Recurring Fevers	□ Growing/Back Pains
□ Constipation	□ Aspergers	□ Autism	□ Skin Conditions	□ Sensory Processing
□ Colic	□ Bed Wetting	□ Car Accident	□ Temper Tantrums	□ Other_________

Purpose For Contacting Us: ____

Have other doctors been seen for this condition? N / Y , if Y, Doctor's Names and Prior Treatments

(Including Medication) :____

____

Date of Onset:___/___/_______ Onset was: □ Sudden □ Gradual □ Associated with an event

Duration of problem or episode: □ Minutes □ Hours □ Days □ Months □ Years

Pattern of problem: □ Constant □ Intermittent □ Occasional □ Cyclical

Initiating Factors:____

Aggravating Factors:____

How does the problem affect your child's body function and daily activities?________________________

____

Prior occurrence or episodes?____

Other health concerns?____

____

Previous Chiropractor: ____

Date of Last Visit: ___/___/_______Reason: ____

Name of Pediatrician: ____

Date of Last Visit: ___/___/_______Reason: ____

Are you satisfied with the care your child receives? Y / N

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History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: ________________weeks

Was the birth assisted: □ No □ Yes: If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labor

Were medications given to mother at time of birth? □ Yes □ No If yes, what? ________________ Duration of birth:_______

Was the delivery normal? □ Yes □ No: If no, what complications were there at birth? ___________________________________

APGAR at Birth: _________ APGAR after 5 minutes: _________ Birth Weight: _________ Birth Length: _________

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No: If no, explain: ________________________

At what age did the child: Respond to sound? _______ Follow an object? _______ Hold up head? _______ Vocalize? _______

Sit alone? ______ Teethe?_______ Crawl ?_______ Walk?_______ Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes, Autoimmune issues, etc)

____

The father's side?

____

Do the child's siblings have any health problems? □ No □ Yes: If yes, describe:____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke? □No □Yes 2. Drink alcohol? □No □Yes 3. Take supplements/vitamins? □No □Yes

4. Take drugs? □ No □ Yes If yes, what? __________________ 5. Become ill? □ No □ Yes: If yes, how________________

____

5. Receive ultrasounds: □No □Yes: If yes, how many? ____6. Receive invasive procedures (i.e. amniocentesis, CVS)? □No □Yes

Was your child breast fed? □ No □ Yes: If yes, for how long? ________ weeks months years

At what age was: 1a. Formula introduced? _____ b. Brand? ________ 2. Cow's milk? _____ years 3. Solid foods? _____years

Did your child receive vaccinations? □ No □ Yes: If yes, which ones? _________________________Any reactions? □ Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses and why? ______________________________________

Any pets at home? □ No □ Yes Any smokers at home? □ No □ Yes If yes, how much? ________________________________

Psychological Stressors

Any difficulties w/ lactation? □ No □ Yes Any problems bonding? □ No □ Yes Does your child seem normal to you? □ No □ Yes

Does the child have any behavior problems? □ No □ Yes If yes, what? ____

Any emotional family issues (i.e. divorce, death, etc) □ No □ Yes If yes, what?____

Does your child have difficulties sleeping (i.e. night terrors, sleep walking, etc)? □ No □ Yes If yes, specify: ________________

Did your child go to daycare? □ No □ Yes: From what age? ______years Average # of hours of TV/Computer per week? ___hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth

□ Respiratory depression □ Cord around neck □ Other ____

Any falls/accidents during pregnancy? □ No □ Yes Has the child had any major falls since birth? □ No □ Yes If yes, did the child need stitches or cause a fracture? Please describe: ____

Any hospitalizations? □ No □ Yes Please explain: ____

Does your child play sports? □ No □ Yes Number of hours per week? ______ Age child began: _____years

Weight of school backpack? _____lbs Approx. hours spent at play per week? ______hours

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Financial Agreement

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our clients are able to receive the needed care in an affordable manner. Financial reimbursement through insurance coverage is based on a contract between you and your insurance company. If you would like to use your insurance, we will be happy to supply you with a weekly statement that you can submit to your insurance. Reimbursement amounts will vary based on your specific insurance policy. Insurance companies do not provide reimbursement for wellness care. Payment is your responsibility and is due at the time of service. **The doctor will discuss all fees before any services are provided**.

I have read and understand the statements above.

Name: ______________________________Signature:___________________________Date:___/___/____

In the case that there are outstanding charges over 60 days, we will keep a credit card on file to be charged the balance on your account.

Name on card: ______________________________________Type of Card: _________________________

Card Number:____Expiration Date:___/___/____

Authorization for Care of Minor: I hereby authorize this office and its doctors to administer care to my child as they deem necessary.

Signed: _____________________________Witnessed: ______________________________________

INSURANCE

Company__________________________ID #_____________________ Group #_____________________

Secondary Insurance ________________ID# ______________________ Group# ______________________

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Release: I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information requested for payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Signature **Date**

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity subluxation: A misalignment of one or more of the extremity joints resulting in alteration of nerve function, joint function, and the surrounding supporting soft tissue structures (ligaments, muscles, fascia).

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek services of another health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only methods are specific adjustments to correct vertebral subluxations, extremity subluxations, and offer nutritional and rehabilitative support for those subluxations.

Education on nutrition, exercise, stress management, wellness and overall wellbeing will be included throughout care.

ACCEPTANCE

I, ____________________________________have read and fully understand the above statements.

Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____

Signature **Date**

Consent to evaluate and adjust a MINOR child

I, ___________________________________being the parent or legal guardian of ____________________________________

Print Name **Print Child's Name**

I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____

Signature **Date**

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Chiropractic Informed Consent

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

The nature of chiropractic treatment includes therapeutic ice and the chiropractic adjustment, where the doctor will use his/her hands to move specific joints. There will typically be an associated sound with the movement, similar to popping knuckles.

Like most health care procedures, there are possible risks associated with the chiropractic adjustment. However, unlike many such procedures, these documented risks are extremely rare. The following are the known risks.

It is not uncommon to experience temporary soreness as if going to the gym for the first time. A very small percentage of people may feel pain, tingling or numbness, cramps or tightness in their extremities.

When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

There is a one in ten million chance of a rare type of stroke associated with certain types of cervical (neck) manipulation. We do not employ that type of procedure at this office. In addition, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.

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. Including prescribed 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 risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

The risk of remaining untreated will allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles.

I have read the explanation above. I will have had the opportunity to have any questions answered to my satisfaction. I acknowledge that no guarantee can be given as to the results or outcome of my care. I have fully evaluated the risks and benefits of undergoing treatment, and hereby give my full consent to treatment.

____________________ ____________________ ____________

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

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