

Pediatric Health History

Welcome to Amarillo Family Wellness Group

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family. Please print clearly filling this out completely prior to your appointment time.

Patient Information	Contact Information
Date: _____ Male/Female (circle one) Name: _____ Nickname: _____ Birth date: _____ Age: _____ Social Security # _____ Address: _____ City: _____ State: _____ Zip: _____	Parents Name (s): _____ Home Phone: _____ Mom Cell Phone: _____ Dad Cell Phone: _____ Parent's Email Address (for patient newsletter and office information) _____@_____

Whom May We Thank for Referring Your Child? _____

Health Information	Insurance
<p>Please check reasons for pursuing chiropractic care for your child:</p> <p><input type="checkbox"/> She/He is continuing ongoing care form another chiropractor.</p> <p><input type="checkbox"/> I recently had my spine checked and I see the value in getting my child checked.</p> <p><input type="checkbox"/> I'm concerned about his/her health and I'm looking for answers.</p> <p><input type="checkbox"/> I want to improve my child's immune function.</p> <p><input type="checkbox"/> I have no idea why we're here. Please take the time to explain to me what you do for children.</p> <p><input type="checkbox"/> She/ He has a specific condition that concerns me. Explain condition or symptom: _____ _____ _____ _____</p>	<p>A superbill will be provided upon request for you to submit to your insurance company for reimbursement directly to you.</p> <p>I hereby authorized the doctor to release all information regarding my records if needed. Initials _____</p> <p>I understand that I am financially responsible for all charges. Initials _____</p> <p>Whom May We Thank for Referring You? _____</p> <p>In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously.</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> Postural Imbalance <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Ear Infections <input type="checkbox"/> Scoliosis <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Seizures <input type="checkbox"/> Bedwetting <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Colic <input type="checkbox"/> Growing/ Back Pains <input type="checkbox"/> Car Accident <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Frequent Colds Other: _____</p>

Health History

Has your child ever seen a chiropractor before? _____ Approximate last date adjusted? _____

Names of other doctors who have cared for you: _____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan: _____

Medications and Supplements your child is taking:

Number of rounds of Antibiotics taken: During last 6 months: _____ In Lifetime: _____

Reasons: _____

Number of rounds of Other Prescription Medications Taken: During last 6 months: _____ In Lifetime: _____

Reasons: _____

Prenatal History

Adopted? No Yes

Complications during pregnancy? No Yes List: _____

Complications during delivery? No Yes List: _____

Birth Intervention: Mother Medicated (Pitocin, etc.) Caesarian Section Forceps
 Vacuum Extracted Emergency

Genetic Disorders or Disabilities? No Yes List: _____

Trauma History

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child? Yes No

List: _____

Is/ Has your child been involved in any high impact or contact type sports (i.e. soccer football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? No Yes

List: _____

Has your child been seen on an Emergency Basis? No Yes

List: _____

Has your child ever had surgery? No Yes List: _____

Has your child ever been involved in a car collision? No Yes List: _____

Other traumas not described above? List: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPTION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I herby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charge by this office.

Parent Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information.

A complete copy of this document is available upon request.

Parent Signature _____ **Date** _____

- I give permission to use my child's photo in the office as witness and celebration of my wellness.
- I give permission to use my child's name in the office if I refer a new member to the practice.
- I understand that if my child is chosen as Patient of the Week, I give permission for certain information about my child's case to be disclosed within the office.
- If I choose to give a testimonial of my child's experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Parent Signature _____ **Date** _____

Informed Consent to Chiropractic Care

Patient: Please discuss any questions or concerns with the doctor and/ or associates.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by the doctor, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor looks for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1st and 2nd degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered over-the-counter analgesics and rest
- Medical care with prescription drugs
- Hospitalization
- Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor’s interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this

treatment has been given.

Date: _____

Printed Name of Patient

Signature of Patient

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Health: A 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 alternation 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.

We do not offer to diagnose or treat any disease or condition other than vertebral 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 that you seek the services of a 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 method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

I understand if I have any questions I am able to ask the doctors, their associates and staff.

I, therefore, accept chiropractic care on this basis.

Signature

Date