onefamily
CHIROPRACTIC

PEDIATRIC HEALTH HISTORY

Welcome to One Family Chiropractic. To allow us to serve you better, and expedite your office visit, please fill out the form below to the best of your ability. If a section does not apply, simply write N/A

Child's Personal Information

Child's Name: Parent/ Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Email: Child's SS #: Birthday: Age:

Whom can we thank for referring you? (Check all that apply) Height: ft. In. Weight: lbs.

- ☐ Current Client
- ☐ Community Event
- ☐ Facebook
- ☐ Family Member
- ☐ Friend
- ☐ Google
- ☐ Instagram
- ☐ Pediatric Doctor, Speech Therapist, Occupational Therapist
- ☐ Webinar/Workshop
- ☐ Website
- ☐ Other

Health Care Practitioner History

Has your child ever received chiropractic care? ☑ Yes ☐ No If so, name:

Reason for care How long Date of last visit

How was their experience?

Have you ever consulted or do you regularly consult with any of the following providers for your child?

Check all that apply: ☐ Psychotherapist ☐ Massage Therapist ☐ Homeopath ☐ Energy Healer ☐ Naturopath ☐ Acupuncturist ☐ Other

Pediatrician's name Date of last visit

Reason for Seeking Health

Current Health Conditions

What Health Condition(s) bring your child into our office?

Have your child received care for this problem before? ☑ Yes ☐ No If yes, please explain

When did the condition(s) first begin?

How did the problem start? ☑ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☑ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem better? What makes the problem worse?

How did the problem start? ☑ Work ☐ Sleep ☐ Hobbies ☐ Exercise ☐ Daily Routines

Pregnancy & Fertility History

Please tell us about your pregnancy

Any fertility issues? ☑ Yes ☐ No If yes, please explain:

Did mother smoke? ☑ Yes ☐ No If yes, how many per week?

Did mother drink? ☑ Yes ☐ No If yes, how many per week?

Did mother exercise? ☑ Yes ☐ No If yes, please explain:

Was mother ill? ☑ Yes ☐ No If yes, please explain:

Any ultrasounds? ☑ Yes ☐ No If yes, please explain:

Your birth team included: ☑ Prenatal Chiropractor ☐ OBGYN ☐ Doula ☐ Midwife

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Has your child ever experienced or currently present with any of the following:

Balanced Brain and Nervous System

- ☐ High Energy
- ☐ Few Symptoms
- ☐ Resistant to Infections
- ☐ Positive Mental Attitude
- ☐ Mentally Alert
- ☐ Excellent Health
- ☐ Active
- ☐ Vibrant

Unbalanced Brain and Nervous System

UNDER-AROUSED

- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking Motivation
- ☐ Poor Concentration
- ☐ Spaciness
- ☐ Constipation
- ☐ Low Pain Threshold
- ☐ Difficulty Walking
- ☐ Worry
- ☐ Irritable
- ☐ Low Energy

Low → Moderate → Severe

UNSTABLE

- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Sleepwalking
- ☐ Hot Flashes
- ☐ PMS
- ☐ Food Sensitivities
- ☐ Bed Wetting
- ☐ Eating Disorders
- ☐ Bipolar Disorders
- ☐ Mood Swings
- ☐ Panic Attacks

Low → Moderate → Severe

OVER-AROUSED

- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Tight Muscles
- ☐ Teeth Grinding
- ☐ Anxiety
- ☐ Heart Palpitations
- ☐ Restless Sleep
- ☐ Poor Expression of Emotions
- ☐ Poor Immune System
- ☐ Racing Mind
- ☐ High Blood Pressure
- ☐ Accelerated Aging
- ☐ Irritable Bowel

- ☐ Poor Presence
- ☐ Decrease Productivity
- ☐ Lack of Profit

Labor & Delivery History

Child's birth was: ☑ Natural vaginal birth ☐ Scheduled C-section ☐ Emergency C-section

At how many weeks was your child born?

Child's birth was: ☑ At home ☐ At a birthing center ☐ At a hospital Other:

Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

☑ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps

☐ Other

Please decscibe any other concerns or notable remarks about your child's labor and/ or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: After 5 min.:

Growth & Development History

Is/was your child breastfed? ☑ Yes ☐ No If yes, how long?

Difficulty with breastfeeding? ☑ Yes ☐ No

Did they ever use formula? ☑ Yes ☐ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ☑ Yes ☐ No

If yes, please explain

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☑ Yes ☐ No

If yes, please explain

At what age did the child: Respond to sound: Follow an object: Vocalize: Sit alone: Walk:

Hold their head up: Begin cow's milk: Begin solid foods: Teethe: Crawl:

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ☑ No ☐ Yes, on a delayed or selective schedule ☐ yes, on schedule

If yes, please list any vaccination reactions:

Has your child received any antibiotics? ☑ Yes ☐ No

If yes, how many times and list reason:

Night terrors or difficulty sleeping? ☑ Yes ☐ No If yes, please explain:

Behavioral, social or emotional issues? ☑ Yes ☐ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ☑ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Please indicate if your child has ever experienced or currently experiences any of the emotional stresses below: (check all that apply)

☐ Age child began daycare ☐ Feel better quickly ☐ Correct the cause of a problem as well as relief
☐ Prevent future problems ☐ Live a healthier lifestyle ☐ Healthier spine and nervous system
☐ Optimal health on all levels ☐ Academic pressure ☐ Loss of a loved one ☐ Bullying
☐ Lifestyle change ☐ Parents' divorce ☐ Relocation New sibling

Your Child's Health Goals

What are the top three health goals?

1.
2.
3.

How do you expect to achieve these goals?

1.
2.
3.

If your concerns for your reason of care went away, how would it change your life?

Acknowledgement & Consent

Patient Signature: Date:

Thank you for trusting One Family Chiropractic to connect you and your entire family with health and happiness

Terms Of Acceptance

When a patient seeks chiropractic health care, and we accept a patient for such care, both parties need to be working towards the same objective. Each patient must understand both the objective and the method that will be able 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 adjustments 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 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. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

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 evaluation, 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 subluxations.

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

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 for my child on this basis.

Child's Name: (printed) _____

Parent/Legal Guardian's Name: (printed) _____

_____ _____

Signature Date

Consent To Care

I do hereby authorize the doctor of One Family Chiropractic to administer chiropractic care that is necessary for my child's particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my child's health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also clearly understand that if I do not follow the doctors specific recommendations at One Family Chiropractic that I will not receive the full benefit from the services, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, One Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. One Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand, and hereby request chiropractic care for my child based on the terms of acceptance and the consent to care.

Parent/Legal Guardian's Name: (printed) _____

_____ _____

Signature Date

Healthcare Authorization

The following authorizes One Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to One Family Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related-emails and information about treatment alternatives or other health related information, as well as my advertisements, newsletters, or patient of the week/month postings.

I give permission to One Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during my treatment. Should I need to speak with a doctor in private, the doctor will provide a private room for these conversations.

By signing the following you are giving One Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Parent/Legal Guardian's Name: (printed) _____

_____ _____

Signature Date

Acknowledgement Of Receipt & Notice Of Privacy Practices

I,_____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: 1) The right to review the notice prior to signing this consent 2) The right to object to the use of my health care information for directory purpose. 3) The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Parent/Legal Guardian's Name: (printed) _____

_____ _____

Signature Date