The Wellness Choice Center

# PEDIATRIC HEALTH HISTORY

## Welcome to Wellness Choice Center

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

Date: __________________ Male/Female (circle one)

Name:________________________________________

Nickname:______________________________________

Birth date: ____________________________ Age:_____

Social Security # _______________________________

Address:_______________________________________

City:____________________ State:_______Zip:________

## Contact Information

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

**Please check reasons for pursuing chiropractic care for your child:**

__ **She/He is continuing ongoing care form another chiropractor.**

__ **I recently had my spine checked and I see the value in getting my child checked.**

__ **I'm concerned about his/her health and I'm looking for answers.**

__ **I want to improve my child's immune function.**

__ **I have no idea why we're here. Please take the time to explain to me what you do for children.**

__ **She/ He has a specific condition that concerns me.**
**Explain condition or symptom:**
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

## Insurance

We will be happy to verify your insurance benefits and find out if you have any chiropractic coverage. However, we do collect payment in full for services rendered on the 1st visit.

Do you have insurance you would like to submit?
Yes No

I hereby authorized the doctor to release all information regarding my records if needed.

Initials_____

I understand that I am financially responsible for all charges.

**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.**

__ **Headaches** __ **Postural Imbalance** __ **Asthma**

__ **Allergies** __ **Ear Infections** __ **Scoliosis**

__ **ADD/ADHD** __ **Autism** __ **Seizures**

__ **Bedwetting** __ **Sinus Problems** __ **Colic**

__ **Growing/ Back Pains** __ **Car Accident**

__ **Digestive Problems** __ **Frequent Colds**

__**Other**:_______________________________________

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## 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:_____________________________________________________

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**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIAPTION 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 in 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