# CHILD HEALTH INTAKE

4 to 8 years old

## ABOUT THE CHILD

NAME:

ADDRESS:

CITY: | STATE/ZIP CODE:

HOME PHONE:

DATE OF BIRTH: | AGE: | GENDER:

HEIGHT: | WEIGHT:

SIBLINGS NAMES AND AGES:

## GENERAL HISTORY

DOES YOUR CHILD EAT WELL ❑ YES ❑ NO

ARE YOU AWARE OF THE IMPACT NUTRION CAN HAVE ON YOUR CHILD'S BEHAVIOR? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ABOUT NUTRION FOR YOUR CHILD? ❑ YES ❑ NO

DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS ❑ YES ❑ NO

DOES YOUR CHILD SLEEP WELL ❑ YES ❑ NO

DOES YOUR CHILD SLEEP ON HIS/HER ❑ SIDE ❑ STOMACH ❑ BACK

PLEASE DESCRIBE HIS/HER SLEEPING HABITS:

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO

IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED:

❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

LIST PRESCRIPTION MEDICATION/SUPPLEMENTS TAKEN:

LIST ANY ALLERGIES YOUR CHILD HAS :

## ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:

ADDRESS:
❑ SAME AS ABOVE

CITY: | STATE/ZIP CODE:

HOME PHONE: | CELL PHONE:

EMAIL ADDRESS:

EMPLOYER NAME:

WORK PHONE: | POSITION TITLE:

## CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION?
❑ YES ❑ NO ❑ DON'T KNOW

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

CHIROPRACTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ CONDITION ❑ WELLNESS
IF CONDITION, PLEASE DESCRIBE:

IS THIS PROBLEM: ❑ OCCASIONAL ❑ FREQUENT ❑ CONSTANT

WHAT MAKES THIS PROBLEM BETTER?

WHAT MAKES THIS PROBLEM WORSE?

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER

HOW DID THIS CONDITION START?
❑ SUDDENLY ❑ GRADUALLY ❑ POST INJURY

WHEN?

HAS THIS CONDITION:

❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ SLEEP ❑ DAILY ROUTINE ❑ EATING ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO

HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT/TESTING:

RESULTS:

**NEW SPRING CHIROPRACTIC**

Phone: 386-227-7534 Email: info@newspringchiro.com

***COMPLETE THIS PAGE FOR CHILDREN 4 to 8 YEARS OF AGE***

## BIRTH HISTORY

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? ❑ YES ❑ NO

DID YOU SUFFER ANY TRAUMAS, FALLS, OR ACCIDENTS? ❑ YES ❑ NO
PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE: ❑MEDICATIONS
❑ TOBACCO/ALCOHO ❑ SUPPLEMENTS

IF YES, PLEASE LIST:

ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO NUMBER: _____

MEDICAL REASON FOR ULTRASOUND?

LOCATION OF BIRTH: ❑ HOME ❑ BIRTHING CENTER ❑ HOSPITAL

WHAT WAS THE BABY'S GESTATIONAL AGE AT BIRTH? _____ WEEKS

DESCRIBE YOUR LABOR/DELIVERY, MARK ALL THAT APPLY:

❑DRUG FREE
❑ LABOR WAS CHEMICALLY INDUCED
❑ C-SECTION DELIVERY
❑ DOCTOR PULLED OR TWISTED BABY
❑SPONTANEOUS
❑ LABOR WAS DOCTOR ASSISTED
❑ FORCEPS/VACUUM EXTRACTION
❑ PREMATURE DELIVERY

PLEASE EXPLAIN:

HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?

HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES: AT 1 MIN _____ /10 AT 5 MIN _____ /10

WAS BABY ALERT & RESPONSIVE WITHIN 12 HRS OF DELIVERY ❑ YES ❑ NO

DID YOU BREASTFEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOU HAVE ANY DIFFICULTY WITH LATCHING OR LACATION? ❑ YES ❑ NO

DID YOU FORMULA FEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOUR CHILD SHOW ANY OF THESE SIGNS OF BIRTH TRAUMA?

❑BRUISNG
❑RESPIRATORY DISTRESS
❑FAST OR EXCESSIVELY LONG BIRTH
❑ODD SHAPED HEAD
❑ STUCK IN THE BIRTH CANAL
❑CORD AROUND NECK
❑LACK OF USE OF ONE ARM
❑ HEAD ROTATED TO ONE SIDE

## GROWTH &DEVELOPMENT

AT WHAT AGE DID THE CHILD:

HOLD UP HEAD _____ TEETHE_____

SIT ALONE _____ WALK_____

CRAWL_____ VOCALIZE_____

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

HOW MANY TIMES/WEEK DOES YOUR CHILD EAT FAST FOOD? _____

CANDY/COOKIES?_____ SODAS?_____

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?
❑ YES ❑ NO

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?
HOW MANY TIMES?:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO
PLEASE EXPLAIN:

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).
WAS THIS THE CASE FOR YOUR CHILD? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?
❑ YES ❑ NO

AT WHAT AGE DID YOUR CHILD START DAYCARE? _____

AVERAGE NUMBER OF HRS OF TV PER WEEK ?_____

ARE THERE ANY SMOKERS LIVING IN THE HOME? ❑ YES ❑ NO

ARE THERE ANY INDOOR PETS IN YOUR HOME? ❑ YES ❑ NO

DO YOU USE GREEN PRODUCTS IN YOUR HOME? ❑ YES ❑ NO

***COMPLETE THIS PAGE FOR CHILDREN 4 TO 8YEARS OF AGE***

## CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC?
❑ YES ❑ NO

ARE YOU AWARE THAT CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT SYMPTOMS OFTEN TIMES ARE THE LAST TO SHOW UP?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?

❑ YES ❑ NO

## FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR CHILD'S FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____ ❑ M ❑ F ❑ S ❑ G

DEPRESSION ❑ M ❑ F ❑ S ❑ G

DIABETES ❑ M ❑ F ❑ S ❑ G

HEART DISEASE ❑ M ❑ F ❑ S ❑ G

LIVER DISEASE ❑ M ❑ F ❑ S ❑ G

HIGH CHOLESTEROL ❑ M ❑ F ❑ S ❑ G

HIGH BLOOD PRESSURE ❑ M ❑ F ❑ S ❑ G

LUNG PROBLEMS ❑ M ❑ F ❑ S ❑ G

SEIZURES ❑ M ❑ F ❑ S ❑ G

NECK PROBLEMS ❑ M ❑ F ❑ S ❑ G

BACK PROBLEMS ❑ M ❑ F ❑ S ❑ G

SCOLIOSIS ❑ M ❑ F ❑ S ❑ G

OSTEOARTHRITIS ❑ M ❑ F ❑ S ❑ G

RHEUMATOID ARTHRITIS ❑ M ❑ F ❑ S ❑ G

AUTOIMMUNE DISEASES ❑ M ❑ F ❑ S ❑ G

OTHER:_____

## YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1._____

_____

2._____

_____

3._____

_____

## SYSTEMS REVIEW

THE EFFECTS OF SUBLUXATION CAN BE BROAD AND FAR REACHING. THEY CAN SHOW UP AS OTHER HEALTH CONCERNS. PLEASE MARK ALL CONDITIONS/SYMPTOMS YOUR CHILD HAS EXPERIENCED:

❑ ACID REFLUX
❑ BED WETTING
❑ CONSTIPATION
❑ EAR INFECTIONS
❑ DIARRHEA
❑ COLIC
❑ ASTHMA
❑ POOR COORDINATION
❑ BRONCHITIS
❑ SLEEPING DIFFICULTIES
❑ NECK PAIN
❑ LOW BACK PAIN
❑ DIFFICULT WEIGHT GAIN
❑ LEARNING DISORDERS
❑ DIARRHEA
❑ FREQUENT COLDS/COUGHS/FLUS
❑ HYPERACTIVITY
❑ HEDACHES
❑ FEVERS
❑ SORE THROATS
❑ ALLERGIES
❑ URINARY PROBLEMS
❑ UPPER BACK PAIN
❑ SHORTNESS OF BREATH

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

WHAT CHANGES (IF ANY) WOULD YOU LIKE TO SEE ACCOMPLISHED IN YOUR CHILD'S HEALTH OR BEHAVIOR?

IF YOU HAVE ANY OTHER CONCERNS NOT PREVIOUSLY LISTED ON THESE FORMS, PLEASE WRITE THEM IN U SING THE SPACE BELOW.

THANK YOU FOR CHOOSING VERITY HEALTH CENTER AND HELPING US TO CONTINUE ON OUR MISSION TO
***HELP FAMILIES EXPERIENCE TRUE HEALTH!***

## NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

**To receive text and/or email appointment reminders, initial here_____**

*I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

| PATIENT NAME (PLEASE PRINT): | RELATIONSHIP TO PATIENT: |
|---|---|
| SIGNATURE: | DATE: |

## Informed Consent to Care for Treatment of a Minor (under 16 years old)

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.

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 circumstance. 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 Name: _____ Signature: _____ Date:
Parent or Guardian: _____ Signature:_____ Date:
Witness Name: _____ Signature:_____ Date: