



CHILD HEALTH INTAKE

9 to 17 years old

ABOUT THE CHILD

NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:		
DATE OF BIRTH:	AGE:	GENDER:
HEIGHT:	WEIGHT:	
SIBLINGS NAMES AND AGES:		

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAS YOUR CHILD EVER BEEN CHECKED FOR VERTEBRAL SUBLUXATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
CHIROPRACTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

GENERAL HISTORY

DOES YOUR CHILD EAT WELL <input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU AWARE OF THE IMPACT NUTRION CAN HAVE ON YOUR CHILD'S BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE MORE INFORMATION ABOUT NUTRION FOR YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD HAVE DAILY BOWEL MOVEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD SLEEP WELL <input type="checkbox"/> YES <input type="checkbox"/> NO
DOES YOUR CHILD SLEEP ON HIS/HER <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH <input type="checkbox"/> BACK
PLEASE DESCRIBE HIS/HER SLEEPING HABITS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):
LIST PRESCRIPTION MEDICATION/SUPPLEMENTS TAKEN:
LIST ANY ALLERGIES YOUR CHILD HAS :

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: <input type="checkbox"/> CONDITION <input type="checkbox"/> WELLNESS IF CONDITION, PLEASE DESCRIBE:
IS THIS PROBLEM: <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT <input type="checkbox"/> CONSTANT
WHAT MAKES THIS PROBLEM BETTER?
WHAT MAKES THIS PROBLEM WORSE?
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER
HOW DID THIS CONDITION START? <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> POST INJURY
WHEN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> EATING <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME AND SPECIALTY:
TYPE OF TREATMENT/TESTING:
RESULTS:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ADDRESS: <input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:

NEW SPRING CHIROPRACTIC

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

COMPLETE THIS PAGE FOR CHILDREN 9 to 17 YEARS OF AGE

BIRTH HISTORY

GROWTH & DEVELOPMENT

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 SPONTANEOUS
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY 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?

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

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 9 TO 17 YEARS 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

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:

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

PLEASE LIST ANY OTHER SYMPTOMS YOUR CHILD HAS EXPERIENCED:

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 _____
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | DEPRESSION
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | DIABETES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HEART DISEASE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | LIVER DISEASE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | HIGH CHOLESTEROL
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| HIGH BLOOD PRESSURE
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | LUNG PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | SEIZURES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| NECK PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | BACK PROBLEMS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | SCOLIOSIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| OSTEOARTHRITIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | RHEUMATOID ARTHRITIS
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | |
| AUTOIMMUNE DISEASES
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | | |

OTHER: _____

YOUR HEALTH GOALS

WHAT ARE YOUR TOP 3 HEALTH GOALS FOR YOUR CHILD?

1. _____
2. _____
3. _____

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 USING 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: _____