Bruce Street
FAMILY CHIROPRACTIC

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this appointment: _____

Have you tried anything to ease this problem? _____

If you don't get this problem corrected, do you think it will get worse in the next 5-10 years? □ yes □ no

On a scale of 1 to 10 (10 being the highest), what is your commitment to getting this problem corrected and improving your child's health? (Circle)

1 2 3 4 5 6 7 8 9 10

Very Low **Moderate** **Very High**

Birth – 4 Years

□ fall from change table
□ fall down stairs
□ involved in car accident
□ fall from playground equipment
□ play in a 'Jolly Jumper'
□ frequent ear infections
□ frequent crying spells
□ frequent fevers
□ frequent bouts of diarrhea
□ constipation
□ colic
□ sleeping problems
□ frequent colds

Vaccinations

□ tetanus
□ polio
□ measles
□ mumps
□ rubella
□ pertussis
□ hepatitis B
□ reactions to vaccinations?

_____

_____

_____

□ diphtheria
□ h*aemophilus Influenzae* type b
□ rotavirus
□ pneumococcal disease
□ varicella
□ meningococcal disease
□ influenza
□ human papillomavirus

Has your child experienced any of the following?

5 - 12 Years

□ fall from tree
□ fall off bicycle
□ fall from playground equipment
□ hyperactivity
□ sports accident
□ involved in car accident
□ injury from siblings
□ stomach pain
□ learning disability
□ allergies / hay fever
□ asthma
□ other_____

□ headaches
□ dizziness
□ tinnitus
□ earaches
□ allergies / hay fever
□ asthma
□ frequent colds
□ fatigue
□ sleeping difficulties
□ mood changes
□ "growing pains"
□ excessive gas / bloating
□ stomachaches

□ walking problems
□ tingling or numbness
arms / hands / fingers
hips / legs / toes
□ pain
neck / shoulders / arms
back / legs / knees / ankles
□ spinal curvature
□ jaw problems
□ fever
□ nervousness/depression
□ anxiety / fear
□ other _____

Which of the problems that you've checked off are you most concerned about?

_____

_____

_____

Is there anything else you feel we should know?

_____

_____

_____

By signing here, I verify that the above information is true and accurate regarding my child's health history.

Signature: _____ Date: _____

DR. ADAM BROOKES ~ DR. LESLEY EVANS ~ FAMILY CHIROPRACTORS
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Our Vision … A Healthier Community, One Family at a Time

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PEDIATRIC CONFIDENTIAL PATIENT HEALTH RECORD

Child's Name:	Parents' or Guardians' Name:		Date:
Address:		City:	Postal Code:
Home Phone: ( )	Extended Health Insurance? □yes □no Details:	Child's Date of Birth D M Y	Age: Sex: □Male □Female
Special needs or allergies		Height	Weight
Have your child ever received chiropractic care before? □yes □no If yes, approximate date of your child's last visit: Doctors name:			
Child's current medications, if any?		MD's name:	
Spinal x-rays taken in the last 12 months? □yes □no Body Part(s):		How did you hear about our office?	

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your child's health expression. Our goal is to uncover the layers of injury or damage (especially to your child's nervous system), that result in lowered health. Following the consultation, the doctor may recommend a specific course of examinations in order to determine whether your child has spinal nerve stress causing interference with inborn health potential.

LOSS OF WELLNESS

Your child's birth process…

Was the delivery: □long and/or difficult (#of hours____) □forceps □vacuum extraction □caesarean □breech?
□ midwife-assisted □ home birth □hospital birth □APGAR score _____ / 2 minutes _____
Were you given: □drugs □epidural □induced - gel or drip? Other complications? _____

Health Habits…

Did you smoke during pregnancy?..... □yes □no _____packs/week
Do you or any family members currently smoke? ..... □yes □no _____packs/week
Did you drink alcohol during pregnancy?..... □yes □no _____beverages/week
Did you take medication during pregnancy?..... □yes □no what kind? _____
Did you breastfeed ……? □yes □no how long? ____ years / weeks
Does your child exercise regularly?..... □yes □no
Sleeping Posture: □side □stomach □back □restless #of pillows_____
How long does your child sleep per night? Total___hrs. Sleep Quality (circle): Excellent—Good—Fair—Poor

Hospitalization…

Has your child ever been hospitalized?..... □yes □no
If yes, for what cause?_____
Has your child ever been prescribed antibiotics? ..... □yes □no
If yes, how often? _____
Has your child had any surgeries? ……..... □yes □no
If yes, for what? _____

Rate your child's stress level on an average day (circle number):

1 2 3 4 5 6 7 8 9 10

Very Low Moderate Very High

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goal.
Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. (The SUBLUXATION spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the Subluxation through a specific chiropractic adjustment allows the body to function at its optimal level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including diagnostic x-rays, if necessary, on me by the doctor and/or anyone working in this clinic authorized by the doctor.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results expected are not guaranteed, as every person is unique.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, however remote. I wish to rely on the doctor to exercise judgment during the course of care to use procedures which the doctor feels, based upon the facts then known, are in my best interests.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care in this office.

TO BE COMPLETED BY PATIENT

_____ _____
Signature of Patient (Or Parent/Guardian) Print Patients Name

_____ _____
Witness Date Signed

* Females only

PREGNANCY RELEASE

Pregnant? ☐Yes ☐No ☐Unsure

The first day of my last menstrual cycle was ___D /__M /___ Y

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Adam/Dr. Lesley has my permission to perform diagnostic x-rays.

_____ _____
Signature of Patient (Or Parent/Guardian) Print Patients Name

_____ _____
Witness Date Signed