PEDIATRIC FORM

VITAL LIFE CHIROPRACTIC

First Name_____Middle_____Last_____ Today's Date ___/___/___

Parent's Names:_____

Age_____ Male/Female Date of Birth ____/____/_____ SS#_____-_____-_____

Address_____ City_____ State_____ ZIP _____

Phone: Home _____ Cell_____ Phone Provider_____

Email Address _____

Do you have Medicaid? Y/N

Appointment notification preference? Text / Email Notification prior to appointment? 1 day/ 2 days/ 2 hr./ 1 hr.

Who may we thank for referring you into our practice? _____

Concern	**Severity 1-10**	**Start Date**	**Prior Concern?**	**From Injury?**	**Constant/ Intermittent**
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other:_____
Did any of the following happen during delivery:
C-section Delivery Doctor pulled/Twisted baby Anesthesia Labor was induced
Forceps/vacuum Extraction Premature Delivery Special Medical Procedures/Tests
Describe any of the above plus any additional complications experienced during delivery:
_____
Did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:
_____
Did you experience any illness while pregnant? Yes No If yes, explain
_____
Do you have any physical disabilities? Yes No If yes, explain:_____
Birth Weight:_____ Birth Length:_____ APGAR scores (if remembered):_____
Ultrasound used during pregnancy? Yes No Number of times_____
Did you breastfeed the baby? Yes No If yes, how long?_____
Did you formula feed the baby? Yes No If yes, how long?_____
At what age did you introduce solids?_____ Cow's milk_____

LIFESTYLE HABITS

Does your child exercise daily? Yes No How much?_____
Does your child drink soda? Yes No How much/often?_____
Does your child have a positive self-esteem/self-image? Yes No
Does your child watch more than an hour of TV/day? Yes No How much?_____
Does your child eat balanced meals? Yes No
Does your child experience prolonged sadness? Yes No Explain:_____
Does your child have difficulty sleeping? Yes No Explain:_____
Does your child play video games? Yes No How much?_____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first during their first year of life (bed, changing table, stairs, etc.). Was this the case in your child? Yes No Explain: _____
Has your child been hospitalized or had surgery? Yes No Explain:_____
Does your child take any medications? Yes No Explain:_____
Does your child have difficulty interacting with others? Yes No Explain:_____
Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No
Explain:_____
Has your child been involved in any high-impact/contact Sports (soccer, football, martial arts, cheerleading,etc.)
Yes No Please list:_____Are you
aware of any food allergies or intolerance?Yes No Explain:_____
Has your child received all recommended vaccinations? Yes No Explain:_____
Please rate stress levels on a scale of 1 to 10 (10 being the highest) School:1 2 3 4 5
6 7 8 9 10 Personal:1 2 3 4 5 6 7 8 9 10

Has your child had previous chiropractic care? Yes No If YES, when & who? _____

CIRCLE ANY OF THESE CONCERNS THAT YOU HAVE HAD IN THE PAST 2 YEARS

ANXIETY/DEPRESSION	FATIGUE/SLEEP ISSUES
CONSTIPATION/DIARRHEA	ASTHMA/CHRONIC BRONCHITIS
NAUSEA/VOMITING	COLIC/ACID REFLUX
DIABETES	BACK/NECK PAIN/STIFFNESS
BEDWETTING	DIFFICULTY GAINING WEIGHT
OVERWEIGHT	EAR OR OTHER INFECTIONS
FREQUENT SICKNESS	HEADACHES
ADD/ADHD	LEARNING DISORDERS
DETACHMENT/DISTANT	SINUS TROUBLE/ALLERGIES
IRRITABILITY/NERVOUS	AUTISM/ASPERGER'S

OTHER:_____

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE-CANCER--SPINAL SURGERY OR FRACTURE-SEIZURES-SCOLIOSIS-DIABETES

PLEASE WRITE DOWN 3 HEALTH GOALS.

1. _____
2. _____
3. _____

What is your level of commitment to yourself and your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

I HAVE SUBMITTED INFORMATION ON THIS PAPERWORK TO THE BEST OF MY KNOWLEDGE AS OF THE CURRENT DATE

_____ _____

(Signature) (Date)

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, 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 satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

(Print Name)

_____ _____

(Signature) (Date)

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____ _____

(Signature of Guardian for Minor/Child) (Date) (Relationship)

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. The disc will be available within 72 hours of prepayment on any regular practice hours day. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Vital Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above Terms and Conditions.

_____ _____ _____

(Print Name) (Signature) (Date)

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT VITAL LIFE CHIROPRACTIC.

_____ _____

(Signature) (Start Date of last menstruation)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

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

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) (Date)