GREEN CHIROPRACTIC

Alignment matters

BETTER SPINE, BETTER LIFE

Pediatric Patient Application

WELCOME, and THANK YOU for trusting us with your child applying as a patient in our clinic. We are a very unique team specializing in researched, evidence-based spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems.

Because of this specialized approach, we may not accept your child as a patient until we perform the necessary tests that will give us insight into the cause of their condition, allowing us to develop an optimal rehab program for them, and are confident we can help them. If we accept your child as a patient, we will make their health a priority and expect you will as well.

Child Information

Full Name:_____ Date: _____ / _____ / _____ Gender: M F

Home Address:_____ Number of siblings:_____

City, State, Zip:_____ Cell Phone: ☐ N/A ( )_____

Birth Date: _____ / _____ / _____ Age:_____ Social Security #: _____ - _____ - _____

Name of Mother/Guardian:_____

Birth Date: _____ / _____ / _____ Marital Status: S M D W

Home Address:_____ Cell Phone: ( )_____

City, State, Zip:_____ Home Phone: ( )_____

Email Address:_____ Work Phone: ( )_____

Occupation:_____ Employer's Name:_____

Name of Father/Guardian:_____

Birth Date: _____ / _____ / _____ Marital Status: S M D W

Home Address:_____ Cell Phone: ( )_____

City, State, Zip:_____ Home Phone: ( )_____

Email Address:_____ Work Phone: ( )_____

Occupation:_____ Employer's Name:_____

How were you referred to this office?_____

In Case of Emergency

List someone (other than parents/guardians) we may contact in case of an emergency

Name:_____ Phone #: ( )_____ Relationship:_____

Purpose for this Visit - **MAIN** Reason - **ONE** area only

Main reason for this visit (describe): _____

When did these symptoms begin? _____

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: _____

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your child's symptoms? _____

Is there anything that relieves the symptoms? ☐ No ☐ Yes: _____

Have they experienced these symptoms before? ☐ No ☐ Yes, when? _____

Have they already been treated for this? ☐ No ☐ Yes, who did they see? _____

What treatment was performed, and how did they respond? _____

If your child cannot yet verbalize pain levels, please skip to Birth Experience section.

What is their pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Purpose for this Visit - **SECONDARY** Reason - any other areas

Other reason for this visit (describe): _____

When did these symptoms begin? _____

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: _____

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your child's symptoms? _____

Is there anything that relieves the symptoms? ☐ No ☐ Yes: _____

Have they experienced these symptoms before? ☐ No ☐ Yes, when? _____

Have they already been treated for this? ☐ No ☐ Yes, who did they see? _____

What treatment was performed, and how did they respond? _____

If your child cannot yet verbalize pain levels, please skip to Birth Experience section.

What is their pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is their pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Symptoms Chart

Please **shade** the areas of symptoms and **label** the diagram using the following abbreviations.

A Ache

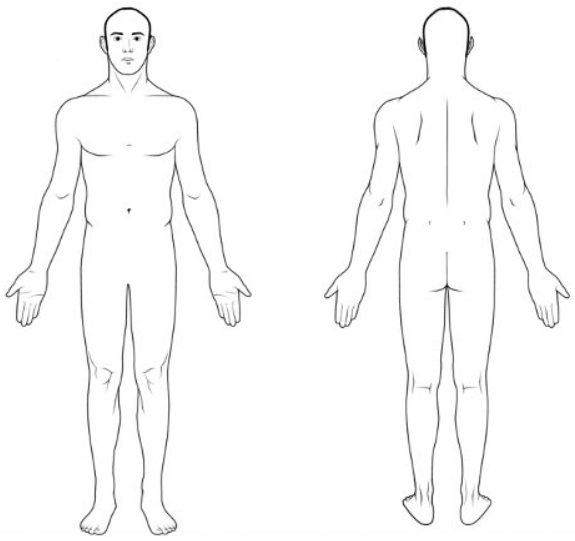
B Burning

S Sharp / stabbing

N Numbness

T Tingling

O Other



Activities of Daily Life

Please mark N/A if your child is not old enough to perform these activities. ☐ N/A

Please identify how your child's current condition(s) is affecting their ability to carry out routine activities.

Choose one for each of the activities below: • Activity has no effect, • They can do activity, but it is painful, • They are limited in the activity, and it is painful, • They are unable to perform the activity.

Activities:	Effects:			
Carrying	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Going Up & Down Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading/Concentrating	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Riding in Car	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform

Birth Experience

Did you experience any of the following during your pregnancy?

☐ Baby in breech position (head up) ☐ Preeclampsia ☐ Severe stress ☐ None

Were there any other problems during pregnancy? ☐ No ☐ Yes

If yes, explain:_____

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Vacuum Extraction ☐ Forceps Assistance

How long was labor?_____

Were there any complications: ☐ No ☐ Yes

If yes, describe: _____

Did or does your child experience any of the following as a newborn?

☐ Distorted skull ☐ Difficulty latching/sucking

☐ Difficulty turning head ☐ Colic

☐ Abnormal posture/head tilt ☐ Reflux

Infant feeding: ☐ Breast ☐ Pumped breast milk from bottle ☐ Formula from bottle

Did/does your child do tummy time? ☐ No ☐ Yes

Did your child skip any milestones? ☐ No ☐ Yes

If yes, which one(s)? ☐ Roll over ☐ Sitting Up ☐ Crawl

At what age did your child start to walk unassisted?_____

Did/does your child exhibit any of the following? Please check all that apply:

☐ Toe walker ☐ Appears clumsy

☐ Sits in a W/frog position ☐ Early walker

☐ Difficulty with crawling - scoots, creeps, army crawls

Has your child been on any antibiotics? ☐ No ☐ Yes, please see below

Why, and how many times?_____

History of Trauma

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine.

Please check any of the following that your child has experienced.

☐ Car accident ☐ Fall off of a swing/slide/jungle gym

☐ Rough shaking as an infant ☐ Fall/accident with a bicycle

☐ Fall from a height of 2 feet or more as a baby ☐ Fall off a skateboard/skates/scooter

☐ Broken bones or debilitating injuries ☐ Fall down stairs

☐ Fall that left a significant bruise or a lump ☐ Other:_____

If any are checked, please explain: _____

_____

Vaccination History

Has your child had any adverse reactions to vaccines? ☐ No ☐ Yes

If yes, explain: _____

Health Conditions

Your child's spine is the foundation of health and core strength in their body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Misalignment of the individual vertebrae or distortion of the normal spinal curves may result in many health conditions. Please answer the following questions accurately so we may determine the full extent of your child's condition.

Please indicate next to all conditions they've experienced (N) = Now, (P) = Past, or (B) = Both

Cervical Spine (Neck) ☐ None

___Neck pain
___Pain in shoulders/arms/hands
___Numbness/tingling in arms/hands
___Coldness in hands
___Weakness in grip
___Headaches
___Dizziness
___Visual/hearing disturbances
___Ear infections
___Jaw pain/clicking
___Thyroid conditions
___Low energy/fatigue
___Recurrent colds/Flu
___Sinus infections
___Allergies/Hay fever

Please explain: _____

Thoracic Spine (Upper Back) ☐ None

___Upper back pain
___Pain on deep inspiration/expiration
___Shortness of breath
___Asthma/wheezing
___Recurrent lung infections/bronchitis
___Heart attack/angina
___Heart palpitations
___Tachycardia (rapid heartbeat)
___Heart murmurs

Thoracic Spine (Mid Back) ☐ None

___Mid back pain
___Pain in chest/ribs
___Indigestion/heartburn
___Acid reflux
___Nausea/upset stomach
___Ulcers/gastritis
___Diabetes
___Tired/irritable after eating or when not have eaten for a while
___Hypoglycemia/hyperglycemia

Please explain: _____

Lumbar Spine (Lower Back) ☐ None

___Low back pain
___Pain in hips/legs/feet
___Numbness/tingling in legs/feet
___Coldness in legs/feet
___Recurrent bladder infections
___Constipation/diarrhea
___Frequent/difficulty in urinating
___Irritable bowel syndrome
___Muscle cramps in legs/feet
___Weakness/injuries in hips/kness/ankles

Please explain: _____

Other Health Information

Child's current primary care physician: _____

Allergies: ☐ None _____

Does your child take any over-the-counter medication? ☐ No ☐ Yes, list how much/often:

_____

Does your child take any prescription medication? ☐ No ☐ Yes, see below

Please list any prescription medications (include name, how much/often, and how long they've been taking it):

Medication	How much/often	Starting Date

Please list any surgeries (include type of surgery and date performed): ☐ None

Surgery	Date

Health History

Are you aware of any poor posture habits? ☐ No ☐ Yes

Explain: _____

Has your child have/does your child have any of the following? Please check the boxes below for the conditions that apply. ☐ None

☐ Cancer	☐ ADHD/ADD	☐ Hernia	☐ Shingles
☐ Heart disease	☐ Depression	☐ Lung disease	☐ Lyme disease
☐ High blood pressure	☐ Migraine headaches	☐ Liver disease	☐ Autoimmune disease
☐ High cholesterol	☐ Diabetes	☐ Kidney disease	☐ Osteoporosis
☐ Circulatory problems	☐ Blood sugar levels	☐ Thyroid problems	☐ Arthritis
☐ Stroke	☐ Gallbladder problems	☐ Fibromyalgia	☐ Broken bones/fractures
☐ Neurological problems	☐ Tonsillectomy	☐ Eczema/psoriasis	☐ Scoliosis
☐ Epilepsey/siezures	☐ Appendectomy		

Please explain: _____

_____

Please list any health conditions not mentioned: _____

_____

Family Health History

Is there any history of spinal problems in your child's family? ☐ No ☐ Yes

If yes, explain: _____

Is there a family history of: ☐ None

	Cancer	Heart Disease	Diabetes	Arthritis	Other
Father	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	_____

Experience with Chiropractic

Has your child seen a chiropractor before? ☐ No ☐ Yes Who? _____

For what? _____

How long was he/she treated? _____ Last treatment: _____ / _____ / _____

How did he/she respond? _____

Did the previous chiropractor take 'before' and 'after' x-rays? ☐ Yes ☐ No

Did he/she recommend a specific course of treatment? ☐ Yes ☐ No

Did he/she recommend a home health care program? ☐ Yes ☐ No

If yes, what? _____

_____

Green Chiropractic Financial Policies

Green Chiropractic will do everything we can to bring out the best in your child and your child's health, but we wish to make it very clear that his/her health is your responsibility. Our financial options are listed below. Please select the appropriate one and sign your acknowledgement of our policy below.

_____Cash

Payment is due at the time services are rendered. We accept cash, check, debit, Visa, Mastercard, Discover and AmEx cards.

_____Insurance Plan

Many insurance policies provide coverage for chiropractic care. Benefits will vary from policy to policy and cannot be guaranteed until an Explanation of Benefits (EOB) is received. Payment on the first visit is required to establish an account. We will contact the primary carrier to obtain benefits and process any claims. Any remaining balance is your responsibility.

_____Medicaid

For managed care plans, WellCare Health Plan and Nebraska Total Care are accepted. We are out of network with United Health Care, so Medicaid provided through United HealthCare will not cover our services. Visit limits and co-pays may apply.

_____Personal Injury

Please provide Green Chiropractic with any accident reports and attorney information. We will send your claims to the auto insurance carrier if you have a MedPay policy. Any remaining balance is your responsibility.

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience to me. The chiropractic office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny the claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

_____ _____

Signature of Legal Guardian Date