Centra
FAMILY CHIROPRACTIC

# Pediatric Form

Name (Legal): Preferred Name:

Age: Date of Birth: Sex: M F

Current Height: Current Weight:

Address:

Email:

Mother's Name: Mother's Phone:

Father's Name: Father's Phone:

Person Financially Responsible for Account (Parent/ Guardian)

Name of person(s) we can discuss your care/account with (name, relationship)

Has your child ever been under chiropractic care before? Y / N Clinic/Doctor's Name:

Who can we thank for referring you or how did you hear about us?

**PRENATAL/BIRTH HISTORY**

Was there any difficulties getting pregnant? Fertility Treatments: Y N

Was there any complications or unusual stressors during the Pregnancy or Labor/Delivery?

Please list any Medications that were taken during pregnancy?

Was there any Cigarette/Alcohol use during pregnancy? Y N

Position of Baby in Third Trimester (Circle One) Breech Transverse Face/Brow Head Down

How far along were you at time of birth? Weeks Day

Circle any applicable Interventions: Pitocin Epidural Episiotomy Forceps/Vacuum C-section Antibiotics

How long was your entire labor? Pushing?

Was the delivery an emergency? Y N If yes, please explain:

Was there presence of? Jaundice (Yellow) Cyanosis (Blue) Congenital Anomalies/Defects:

If yes, please explain:

Child's Birth Weight:

Did your child require additional hospitalization?

**INFANT HISTORY**

Infant feeding (Circle One): Breast Bottle

Did your child have any difficulty with latching or sucking? Tongue Tie? Y N

Number of hours of sleep per night: Quality of Sleep: Good Fair Poor

Has your child ever been hospitalized?

Please list any surgeries your child has had:

Please list any medications your child has taken or is currently on:

Please list any allergies your child has:

**DEVELOPMENTAL HISTORY:**

Please tell us about your child's development? Were there any struggles?

Does your child tend to fall frequently?

Is/has your child been involved in any sports?

Has your child sustained an injury playing sports or from falls?

Has your child ever been involved in a car accident?

**CURRENT HEALTH GOALS**:

Purpose of this visit:

When did this begin?

Has the child had this before? Y N If yes, when?

Have you seen any other Providers for this ? Y N Clinic/Doctor's Name:

If we could help your child achieve/improve three things, what would they be?

1)______________________________ 2)______________________________ 3)__________________________________

What would you like to gain from chiropractic care? (Please Circle One)

Resolve Existing Condition Enhance How Their Body Functions Both

**Check any of the following symptoms in which your child has now (N) or in the past (P):**

**N P**

CERVICAL:

___ ___Colic & Excessive Crying
___ ___Torticollis & Plagiocephaly
___ ___Sever or Frequent Headaches
___ ___Ear or Sinus Infections
___ ___Headaches & Migraines
___ ___Vertigo or Dizziness
___ ___Vision or Hearing Issues
___ ___TMJ/Jaw Pain
___ ___Frequent Colds
___ ___Difficulty Sleeping
___ ___Croup or Chronic Cough
___ ___Sore Throat & Strep

**N P**

___ ___ Epilepsy & Seizures
___ ___ Sensory & Spectrum Issues
___ ___ ADD/ADHD
___ ___ Focus & Memory Issues
___ ___ Anxiety & Stress
___ ___ Balance & Coordination Issues
___ ___Speech Challenges
___ ___ High or Low Blood Pressure
___ ____Reflux/ GERD
___ ____Depression
___ ____Swollen Tonsils & Adenoids

UPPER/MID THORACIC:

___ ___Chronic Colds & Cough
___ ___ Asthma
___ ___ Bronchitis or Pneumonia
___ ___ Immune Deficiency
___ ___ Gallbladder Pain/Issues
___ ___Fevers
___ ___ Liver trouble

___ ___Blood sugar problems
___ ___Rapid or slow beating heart
___ ___Chest pain
___ ___Difficulty breathing
___ ___Indigestion or Heartburn
___ ___Stomach Pain or Ulcers
___ ___High or Low blood pressure

LOWER THORACIC:

___ ___ Excessive Stress & Cortisol
___ ___ Hyperactivity
___ ___ Chronic Fatigue or Low energy
___ ___Poor Metabolism
___ ___ Behavioral Issues

___ ___ Allergies or Eczema
___ ___Skin Conditions & Rash
___ ___ Kidney Problems
___ ___Gas Pain or Bloating

LUMBAR:

___ ___Constipation
___ ___Crohn's/ IBS/Colitis
___ ___Constipation
___ ___Diarrhea

___ ___Bedwetting
___ ___Cramps or menstrual problems
___ ___Painful urination
___ ___Bladder or Urination Issues

## TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

I, (Parent/ guardian)___________________hereby consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Nicholas Centra, Dr. Tara Centra and staff who now or in the future may treat my child while employed by this office. I will have an opportunity to discuss with Centra Family Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Centra Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my child's health history is correct to the best of my knowledge. I will not hold the doctor or any staff member of Centra Family Chiropractic responsible for any errors or omission that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

## PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read, or have had read to me, the full above terms of acceptant and consent to chiropractic services and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff. I have also read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

**Parent/Guardian Signature:** **Date:**

## PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. And, that Centra Family Chiropractic does not take any insurance. I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the case of a pre-pay plan, payments made for services not utilized will be returned.

**Parent/Guardian Signature:** **Date:**

## PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Facebook page or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the circle that applies to you:

- ☐ Sure! You can use my picture on the CFC website, FB page, and/or other social media posts as long as I look good!
- ☐ No thanks! I'll pass for now

**Parent/Guardian Signature:** **Date:**