Pediatric Life Story

Vital Information

Child's Name: _____ Date: _____

Parents'/Guardians' Names: _____

Home Address: _____ City/St/Zip _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's Email: _____

How did you hear about us? _____

Height (of child): _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____

Siblings and ages: _____

Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to child: _____

Phone Number: _____ Alternative phone number: _____

Family Doctor

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, PT, OT, Speech Pathologist, Massage Therapist, Behavioral Therapist, etc.)

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He / She is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He / She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine called the ***vertebrae***. Many of the common health challenges that adults experience have their origins during the ***developmental years***, some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins, and emotional stress***. The result may be misalignment to the spinal column and damage to the nervous system - a condition called ***Vertebral Subluxation***. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal***.

What signals has your child's body been communicating?

Previously	Currently		Previously	Currently		Previously	Currently	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive/ Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds/ Croup	☐	☐	Trouble Feeding on one side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent crying spells	☐	☐	Autism / SPD

Do you have a specific concern that brings you in?

- ☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.
- ☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ For how long? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint?

☐ No ☐ if Yes, whom_____

What treatment did they use? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes: _____

Has your child ever experienced this complaint before? ☐ No ☐ Yes: _____

Has your child received any treatment at this time? ☐ No ☐ Yes: _____

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: _____

Has your child had any blood work done for the complaint? ☐ No ☐ Yes:_____

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (brief description): _____

Ultrasounds during pregnancy: ☐ No ☐ Yes (brief description): _____

Medications during pregnancy: ☐ No ☐ Yes (brief description): _____ If so, which ones and how often? (Include OTC): _____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐ No ☐ Yes (brief description): _____

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birth Center ☐ Other: _____

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ ☐ OB Other: _____

Medications during labor/ delivery (including IV antibiotics): ☐ No ☐ Yes:_____

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: _____

How long was the labor from the first regular contractions to birth? _____ hours.

How long was the second stage (the pushing phase) of the labor? _____ hours.

Was the baby born with any purple markings / bruises on their face or head? ☐ No ☐ Yes

Any concerns about mis-shapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

If known, APGAR score at: 1 minute: _____/10 5 minutes: _____/10

Was the baby ever administered to the NICU? ☐ No ☐ Yes

If yes, for how long and why? _____

Was any medication given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ☐ No ☐ Yes Months: _____

Was your child breastfed + formula fed? ☐ No ☐ Yes Months: _____

Did your child show any sensitivities to formula (reflux, eczema, arching back) ☐ No ☐ Yes

What age did you introduce solid foods to your child? _____months

Did you introduce cereal or grains within your child's first year? ☐ No ☐ Yes

Did your child spend a lot of time in any baby devices (bouncy swings, swings, bumbos, car seats, etc.)?

☐ No ☐ Yes Which ones?

_____

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes _____

Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes _____

Has your child been seen on an emergency basis? ☐ No ☐ Yes _____

Has your child broken any bones? ☐ No ☐ Yes _____

Has your child had any previous hospitalizations? ☐ No ☐ Yes _____

Has your child had any previous surgeries? ☐ No ☐ Yes _____

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child sleep on their.... ☐ Back ☐ Stomach ☐ Sides (both, right, left)

Does your child carry a back pack? ☐ No ☐ Yes

Do they wear their back pack on 2 shoulders? ☐ No ☐ Yes

Does your child show excessive or uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear custom orthotics? ☐ No ☐ Yes, for what purpose?

_____

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed schedule ☐ Yes, on schedule

Reason to vaccinate: _____

Reaction(s) to vaccination: ☐ None ☐ Fever ☐ Diarrhea ☐ Rash ☐ Welt at injection site
☐ Fatigue ☐ Seizures ☐ Prolonged Cry ☐ Development Regression
☐ Other : _____

Does your child receive annual flu shots? ☐ No ☐ Yes (personal research) ☐ Yes (MD recommended)

Has your child been exposed to antibiotics? ☐ No ☐ Yes

If yes, how many doses in past 6 months? _____ Reason: _____

Has your child been exposed to medications, including OTC? ☐ No ☐ Yes

If yes, which ones? _____

If yes, how many doses in past 6 months? _____ Reason: _____

Child's Name: _____

How many glasses of water/day does your child have? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of cow's milk, juice, and soda/ day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
Does your child eat gluten? ☐ No ☐ Yes ☐ Trying to eliminate
Does your child eat dairy? ☐ No ☐ Yes ☐ Trying to eliminate
Any food/drink allergies or sensitivities? ☐ No ☐ Yes _____
Is your child exposed to second hand smoke? ☐ No ☐ Yes _____
Does your child take a probiotic daily? ☐ No ☐ Yes_____ CFU's/day
Does your child take a vitamin D3 daily? ☐ No ☐ Yes_____ IU's/day
Does your child take Omega 3 fish Oils daily? ☐ No ☐ Yes_____ mg/day
Other supplements or homeopathics? _____

Emotional Stressors

Does your child seem happy? ☐ No ☐ Yes
Does your child show signs of depression or sadness? ☐ No ☐ Yes
Does your child show signs of anxiousness or anxiety? ☐ No ☐ Yes
Does your child participate in sports or extracurricular activities? ☐ No ☐ Yes
Does your child have a high quality group of friends who have involved parents? ☐ No ☐ Yes
Does your family have regular family meals? ☐ No ☐ Yes
Has your child experienced bullying? ☐ No ☐ Yes
If yes, share what action steps have been performed: _____

AUTHORIZATION FOR CARE OF A MINOR

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to check and adjust when appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

Parent or Guardian Authorizing Care Signature: _____
Date: _____

Child's Name: _____

NOTICE OF HEALTH CARE AUTHORIZATION & PRIVACY POLICY

I have been offered but have not made a request to review a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to Paragon to conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care.
- I give permission to use my physical address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If Paragon Chiropractic contacts me by my phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to Paragon Chiropractic to use my name and photograph on their welcome board, referral board, bulletin board and other informational material such as their brochure, website, social media sites and articles in print media.
- I give permission to Paragon to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, or their website, or in ads in print media.
- I give Paragon Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other person in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
- 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 of a request
    - You may request to view changes to your record

By signing this form you are giving Paragon Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your Paragon Chiropractic more efficient and productive as well as to enhance your access to quality of Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Paragon Chiropractic plus 7 years unless revoked by me. I also understand that I can request, in writing, that you are restricting how my personal information is used and/or disclosed.

I have read and understand this Healthcare Form. My signature below represents agreement with these practices.

Name of Parent or Guardian (Print) _____

Signature _____ Date _____/_____/_____

OUR FEE STRUCTURE AND FINANCIAL POLICY

Please note our fees for your initial visit:

Consultation, exam and nervous system scan: $149 (unless otherwise stated)

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Also, note that the Report of Findings, the time that your doctor will spend with you to go over your results, is part of the initial visit fee. Recommendations for care are based on necessity and not insurance benefits. We are a cash office and are not in network with any insurance companies.

I CLEARLY UNDERSTAND AND AGREE that I am responsible for all the bills incurred at this office relating to my care. I also understand that if I suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable.

I _____ have completely read and understood the above statement concerning fees and choose to receive care.

Signature _____ Date _____/_____/_____