OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

Infant / Child (under 5) Chiropractic Health Form

Name of Child: _____

Name of Parent(s): _____

Address: _____ City: _____ Postal Code: _____

Parent's Home #: _____ Parent's Cell #: _____ Parent's Office #: _____

Parent's Email: _____

☐ Yes ☐ No I consent to receiving email communication from Oaktree
(Emails we will send you will include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email.)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: _____ Height: _____

Referred by: _____

Do you have extended health care benefits that contribute to chiropractic care?
☐ Yes ☐ No Amount per year: _____

CHIROPRACTIC HISTORY

Has your child ever been to a chiropractor before? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Name of Chiropractor: _____ City: _____

Date of last visit: [M] _____ [Y] _____ Duration & Frequency of Care: _____

ROM						Palpation				Posture
C/S				L/S		C/S	T/S	L/S	S	
LR 90	RR 90	Flex 40	Ext 90	Flex 130	Ext 40					☐ iPad

PRENATAL & BIRTH HISTORY

PREGNANCY

Complications during pregnancy: ☐ Yes ☐ No Comment: _____

Ultrasounds during pregnancy: ☐ Yes ☐ No How many? _____

Medications during pregnancy: ☐ Yes ☐ No If yes, what?: _____

BIRTH

Location of birth: ☐ Hospital ☐ Home ☐ Birthing center ☐ Other: _____

Type of birth: ☐ Vaginal ☐ C-section ☐ Breech ☐ Resuscitation Comment: _____

Complications during delivery: ☐ Yes ☐ No Comment: _____

Medications during delivery: ☐ Yes ☐ No If yes, what?: _____

Birth procedure / interventions: ☐ Forceps ☐ Vacuum extraction ☐ Induced Other: _____

Any evidence of birth trauma? ☐ Fast or excessively long birth ☐ Odd-shaped head ☐ Bruises
☐ Stuck in birth canal ☐ Cord around neck ☐ Respiratory depression Other: _____

Cigarette / alcohol use during pregnancy: ☐ Yes ☐ No Comment: _____

Genetic disorders or disabilities: ☐ Yes ☐ No Comment: _____

Birth weight: _____

FEEDING HISTORY

Was the baby breastfed? ☐ Yes ☐ No If yes, for how long? _____

If applicable, at what age was the baby introduced to:
☐ Formula: _____ Type(s): _____
☐ Solid foods: _____ Type(s): _____
☐ Commercial baby food: _____ Type(s): _____
☐ Cow's milk: _____

CHEMICAL STRESSORS

Any food intolerances? ☐ Yes ☐ No If yes, list: _____

Vaccinations? ☐ Yes ☐ No If yes, list: _____

Antibiotics? ☐ Yes ☐ No If yes, list: _____ Total # of antibiotic rounds to date: _____

Does the child take any medication(s)? Which and for what condition(s)?

_____

_____

TRAUMATIC STRESSORS

Falls the child has experienced (ex. from a bed, changing table, down stairs, off couch ...)
Please list type of fall and approximate date: _____

Has the child ever been hospitalized? ☐ Yes ☐ No Comment: _____

Has the child ever had surgery? ☐ Yes ☐ No Comment: _____

Has the child ever been involved in a car accident? ☐ Yes ☐ No Comment: _____

Does the child play any high impact sports? ☐ Yes ☐ No List: _____

How often does the child participate in aerobic exercises? (at least 30 minutes per day)
☐ 0 days/week ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5-7 days/week

HEALTH CONCERNS

What is the purpose of your visit? ☐ Check-up ☐ Prevention ☐ Specific Concern (Fill out below):

WHAT IS THE PRESENT PRIMARY HEALTH CONCERN FOR THE CHILD?

How long has the child had this condition?

What aggravates this condition?

What relieves this condition?

Other health care professionals who treated this condition? _____

IF APPLICABLE, WHAT IS THE SECONDARY HEALTH CONCERN FOR THE CHILD?

How long has the child had this condition?

What aggravates this condition?

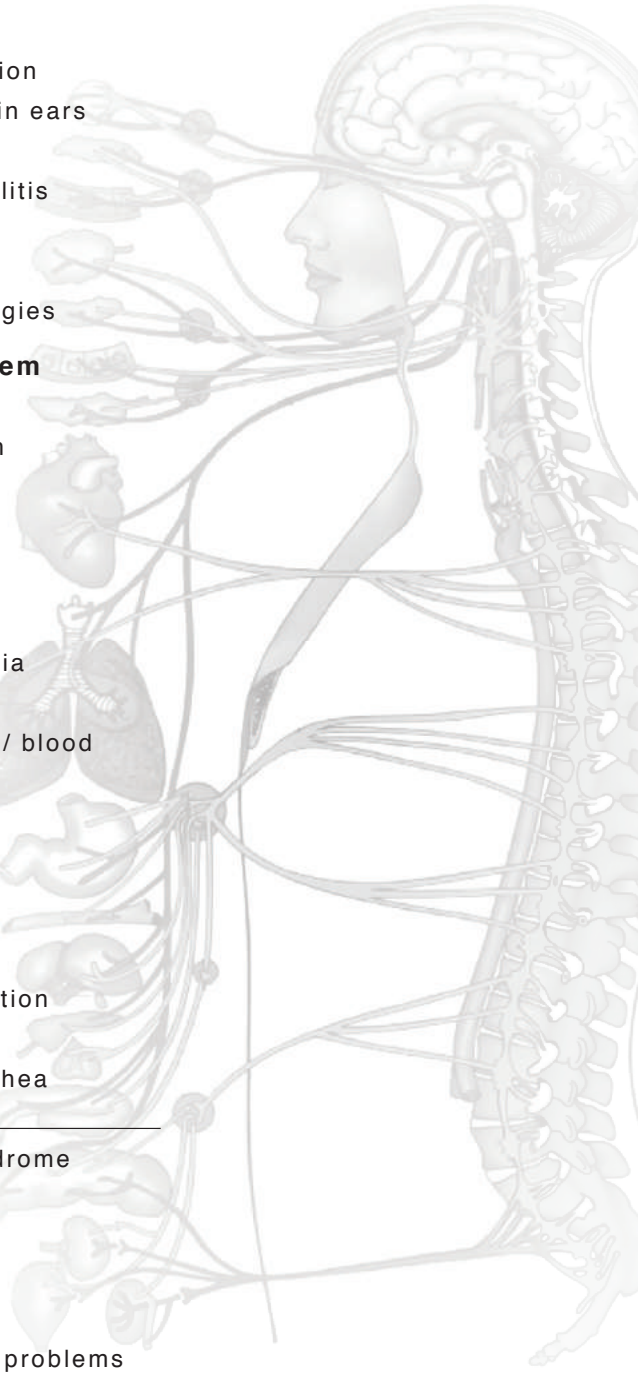
What relieves this condition?

Other health care professionals who treated this condition? _____

OTHER HEALTH PROBLEMS, CONCERNS OR ADDITIONAL INFORMATION

CONDITIONS & SYMPTOMS

PLEASE MARK WITH AN X ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE THE CHILD IS EXPERIENCING. PLEASE CIRCLE ANY THE CHILD HAS EXPERIENCED IN THE LAST 6 MONTHS



Head / Neck

- ☐ Blurred / failing vision
- ☐ Deafness / ringing in ears
- ☐ Earaches
- ☐ Sore Throat / tonsillitis
- ☐ Thyroid problems
- ☐ Sinus problems
- ☐ Environmental allergies

Cardiovascular system

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Heart medication
- ☐ Swelling of legs

Respiratory system

- ☐ Frequent bronchitis
- ☐ History of pneumonia
- ☐ Chronic cough
- ☐ Spitting up phlegm / blood
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma

Digestive system

- ☐ Heartburn / indigestion
- ☐ Stomach cramps
- ☐ Constipation / diarrhea
- ☐ Food allergy: _____
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Ulcers
- ☐ Belching / gas
- ☐ Nausea or vomiting
- ☐ Liver / gall bladder problems
- ☐ Colon trouble
- ☐ Black / bloody stool

Musculoskeletal system

- ☐ Painful joints
- ☐ Painful muscles
- ☐ Tendinitis (location) _____
- ☐ Headaches / migraine
- ☐ Neck pain / stiffness
- ☐ Tension across shoulders, L R
- ☐ Numbness-tingling: arms/hands, L R
- ☐ Numbness-tingling: legs/feet, L R
- ☐ Mid-back pain / stiffness
- ☐ Lower-back pain / stiffness
- ☐ Scoliosis / spinal curvatures
- ☐ Faulty posture
- ☐ Painful tailbone
- ☐ Foot trouble, L R

General symptoms

- ☐ Fever / chills / sweats
- ☐ Frequent colds
- ☐ Fainting / dizziness
- ☐ Seizures / convulsions
- ☐ Skin problems
- ☐ Tremors
- ☐ Loss of balance
- ☐ Unexpected weight loss / gain
- ☐ Anemia
- ☐ HIV / AIDS
- ☐ Loss of sleep
- ☐ Poor memory / concentration
- ☐ Learning disability
- ☐ Irritable / nervous / tension
- ☐ Depression / emotional problems
- ☐ Anxiety
- ☐ Decreased energy / fatigue
- ☐ Tired / lethargic
- ☐ Autoimmune disease
- ☐ Antibiotic use
- ☐ Cancer: _____
- ☐ Other: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. Our goal is to locate and correct vertebral subluxation (misalignments), thereby restoring normal function to the spine, and removing any interferences to nerve function, and maximizing the transmission of nerve impulses from the brain to body. While we often see dramatic improvements in disease and conditions by restoring function to the spine and removing nerve interference, chiropractic is not a treatment of any disease condition.

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 optimum 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 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, as well as any questions I have regarding specific technique performed. 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 manipulation by medical doctors, physiotherapists and chiropractors there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, rib fractures, disc injuries and cerebral vascular accidents (CVA). The best current scientific evidence shows that the risk of cerebral vascular accident (CVA) from oral contraceptives is 1 in 25,000; the risk of CVA in the general population is 1 in 175,000; the risk of CVA from manipulation is 1 in 5,850,000. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is 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 present and future care.

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

TO BE COMPLETED BY PATIENT:

_____ _____

SIGNATURE OF PARENT/GUARDIAN *PRINT PARENT/GUARDIAN 'S NAME*

_____ _____

DATE SIGNED *WITNESS*