Pediatric Health History Form

Newborn to 12 years of age

Adjusted For Life Family Chiropractic • 105 S. Jefferson, Ste B3•Kearney, MO 64465

ABOUT THE CHILD

Today's Date_____

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Phone (_____) _____Carrier_____	Phone (_____) _____Carrier_____
Employer _____	Employer _____
E-mail _____	E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Adjusted For Life Family Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nervous system
❑ Optimal health on all levels
❑ OTHER_____

The primary system in the body which coordinates health and controls function is the NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Misalignments to the SPINE causing interference in the NERVOUS SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in a reduction of optimal health.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects. The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol? _____

Type of Birth:
❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was/is the baby breastfed? ❑ No ❑ Yes For how long? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?
Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, which vaccination schedule are you following? ❑ Standard ❑ Delayed ❑ Other_____
Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke_____
❑ Has taken antibiotics _____
❑ Currently taking medication_____
❑ Currently taking supplements _____
❑ Has allergies _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:
❑ Uncoordinated/Accident prone_____
❑ Has been hospitalized_____
❑ Had a severe trauma_____
❑ Been in an automobile accident _____
❑ Has fractured a bone or dislocated a joint _____
❑ Has/had a chronic illness _____
❑ Has had surgery _____

What physical activities does your child participate in? _____

Did your child crawl? ❑ Yes ❑ No ❑ N/A How long? _____
Issues/Abnormal patterns? Please explain_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

Financial Information

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam: $65

PLEASE READ AND SIGN

1. I acknowledge that Adjusted For Life Family Chiropractic has informed me that they are not in network with and insurance providers. Therefore, they cannot guarantee that claims for any services rendered to me by Dr. Zoe Shelden and/or Adjusted For Life Family Chiropractic will be reimbursed. EXCEPTION: Special circumstances exist for patients qualifying for Medicare which will be discussed at your consultation. Please notify our office in advance of your appointment if possible.
2. I have been informed that a copy of Adjusted For Life Family Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* policy is available for my review both in the office and on the website at www.adjustedforlife.net.
3. I understand that my care is provided in an open setting and that a private room is available upon request.
4. I consent to receive communication from AFL via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
5. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to AFL. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Zoe Shelden and the staff of Adjusted For Life Family Chiropractic permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) _____

Signature of Parent (for minor):_____ Date: _____

I understand that I am directly and fully responsible to Adjusted For Life Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____
Parent or Legal Guardian's Signature Date

_____ _____
Doctor's Signature Date