FAMILY HEALTH
CHIROPRACTIC, PC
Healthy Families by Choice, not by Chance

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Confidential Child Patient Information-Minor

Name_____ Home#_____

Address_____ City/State _____ Zip _____

Age _____ Birth Date _____School _____ Grade _____

Father **Previous Chiropractic Care** Y/N Why?_____

Name_____ Age_____ Birth Date_____

Address_____ City/State_____Zip _____

Employer_____ Business# _____

E-Mail_____Home#_____Cell#_____

Mother **Previous Chiropractic Care** Y/N Why?_____

Name_____ Age_____ Birth Date_____

Address_____ City/State_____Zip _____

Employer_____ Business# _____

E-Mail_____Home#_____Cell#_____

Sibling's Information **Previous Chiropractic Care**

Sibling #1 Name_____ Age____ Birth Date_____ Y/N Why?_____

Sibling #2 Name_____ Age____ Birth Date_____ Y/N Why?_____

Sibling #3 Name_____ Age____ Birth Date_____ Y/N Why?_____

Sibling #4 Name_____ Age____ Birth Date_____ Y/N Why?_____

Other Siblings Names and DOB's _____

Who Can I Thank for Referring You: _____

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? ◯ Yes ◯ No If yes, who? _____

Date of last visit:_____

Name & Address of Obstetrician/ Midwife:

_____

_____

Name & Address of Primary Health Care Provider:

_____

_____

Date of last visit _____ Purpose of visit _____

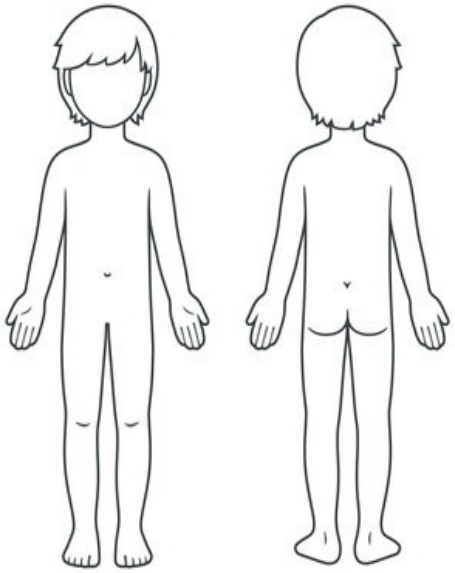
Current Drugs/Medications? _____

_____

Health Concerns
Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Color Any Areas
You are having a complaint.



What is the pain like for each area? (Example- dull, sharp, stabbing, shooting, numb, etc) Does it radiate anywhere Please describe in your own words?

Since the problem started its: Same?☐ Getting Better?☐ Getting Worse?☐

What have you done for this condition? Did it make it better or worse?

Which activities aggravate your condition? What makes it better?

I do (do not) have a family history of this or similar symptoms (Please explain):

PREGNANCY AND BIRTH HISTORY

Gestational Duration: _____ weeks

Physical Stress
Trauma/Falls during pregnancy_____

Any ultrasounds or x-rays during pregnancy? ◯ Yes ◯ No

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis?) ◯ Yes ◯ No

What? _____

Chemical Stress
During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

Any illness during pregnancy? ◯ Yes ◯ No Explain:_____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No (Please list all)

_____

_____

_____

Emotional Stress

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

List any major emotional stresses: _____

LABOR
Was labor induced? ◯ Yes ◯ No

Duration of labor? _____

Duration of active (pushing stage) labor?_____

Did mother receive any pain medication during labor ? ◯ Yes ◯ No (If yes, which ones:)

_____

_____

_____

BIRTH

Type of birth? ◯ Vaginal: Head first ◯ Breech (feet first) ◯ C-Section ◯ Other_____

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No

Please explain:_____

_____

_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising
◯ Stuck in birth canal
◯ Respiratory depression
◯ Failure to feed
◯ Odd shaped head
◯ Fast or excessively long birth
◯ Cord around neck
◯ Other _____

Was your child subjected to any of the following? Check all that apply:

◯ Silver nitrate drops in eyes
◯ Vitamin K shot
◯ Hepatitis B shot
◯ Incubation How long? _____
◯ Separation from you How long? _____
◯ Other _____

Did your child spend any time in intensive care? ◯ Yes ◯ No If yes, how long? _____

Reason: _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Anything else about the birth we need to know? _____

CHILDHOOD HISTORY

Physical Stress

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child have a preferred side to breast-feed? ◯ Yes ◯ No _____

Did your child spit up after feeding as a baby? ◯ Yes ◯ No _____

Any falls from couches, beds, change tables, ? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to present problems).

1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No
2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No
3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body: _____

Does your child play sports? ◯ Yes ◯ No What? _____

If yes, hours per week? _____ Age child began? _____

Is school backpack used? ◯ Yes ◯ No Weight of backpack? _____ lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____

Does your child have trouble reading the board? ◯ Yes ◯ No _____

Does your child have difficulty with coordination? ◯ Yes ◯ No _____

Chemical Stress

Was your child breast-fed? ◯ Yes ◯ No For how long?_____

At what age was:

Formula introduced? Brand(s)? _____

Cow's milk introduced? _____

Solid food introduced _____

Food/juice intolerance? ◯ Yes ◯ No _____

Does your child have food allergies? ◯ Yes ◯ No _____

What is your child's favorite food? _____

What does your child regularly drink? _____

Diet

The type of diet your child usually follows is classified as: _____

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

5 – Multiple Daily | **4** – Daily to Multiple Weekly **| 3** – Weekly | **2** – Multiple Monthly | **1** – Monthly or Less **| 0 -** Do not consume this

_____Eggs	_____Fast Foods	_____ Fresh Fruit	_____Canned Fruit
_____Fish	_____Diet Food	_____Organic Foods	_____Frozen Fruit
_____Coffee	_____Beef	_____Weight Control Diet	_____Raw Vegetables
_____Soft Drink	_____Poultry	_____Artificial Sweetener	_____Whole Grains
_____Fried Foods	_____Seafood	_____Cooked vegetables	_____Nuts
_____Refined Sugar	_____Dairy	_____Canned vegetables	_____Snack Foods

Does your child have a bowel movement every day? ◯ Yes ◯ No _____

Does your child have regular or occasional skin rashes? ◯ Yes ◯ No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative vaccine reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Un-consolable crying ◯ Bowel disturbances ◯ Feeding disturbances

◯ Irritability ◯ Arching of body ◯ Drowsiness ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many coursed of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? ◯ Yes ◯ No _____

Are there any smokers at home? ◯ Yes ◯ No _____

Emotional Stress

Did mother have any difficulties with breast-feeding? ◯ Yes ◯ No _____

Did mother and baby have difficulty bonding? ◯ Yes ◯ No _____

Did mother experience any post-partum depression? ◯ Yes ◯ No _____

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Behavior problems? ◯ Yes ◯ No Explain: _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours:_____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend day care? ◯ Yes ◯ No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain:_____

At what age did your child:

Respond to sound?	_____	Sit alone?	_____
Follow an object?	_____	Teethe?	_____
Hold head up?	_____	Crawl?	_____
Vocalize?	_____	Walk?	_____

FAMILY HISTORY

Describe any medical family history: (Example: cancer, diabetes, hereditary disorders, etc)

On Mother's Side:

- Grandmother: _____
- Grandfather: _____
- Aunts/Uncles: _____

On Father's Side:

- Grandmother: _____
- Grandfather: _____
- Aunts/Uncles: _____

Do siblings have any health concerns or adverse vaccine reactions? ◯ Yes ◯ No

If yes, please describe all: _____

_____

_____

_____

Informed Consent and Terms of Acceptance for Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, cranial bones, or extremities, which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of energy to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neuro-muscular-skeletal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology and how it has adapted to lifestyle stresses. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of subluxations and the promotion of genetically congruent human lifestyle choices.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)

I, _____ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. John Badinger or other attending chiropractor.

_____ _____
(SIGNATURE) (DATE)

Consent to assess and care of a minor:

I, _____, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms of acceptance and
(CHILD'S NAME)
hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

_____ _____
(SIGNATURE) (DATE)