

PLEASE PRINT:

DATE: \_\_\_\_\_

CHILD'S FULL NAME \_\_\_\_\_ PARENT'S HOME PHONE \_\_\_\_\_

PARENT'S FULL NAME \_\_\_\_\_ PARENT'S WORK PHONE \_\_\_\_\_

PARENT'S STREET/P.O. ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

WHAT IS YOUR CHILD'S BIRTHDATE? \_\_\_\_\_ HOW OLD IS YOUR CHILD? \_\_\_\_\_ CHILD'S S.S.# \_\_\_\_\_

## HISTORY OF THE PRESENT ILLNESS/INJURY

PLEASE BE SPECIFIC:

### CHIEF COMPLAINT

PLEASE DESCRIBE YOUR CHILD'S PAIN OR CONDITION

FOR WHAT CONDITION ARE YOU CONSULTING THE DOCTOR? \_\_\_\_\_

WHEN DID IT BEGIN? \_\_\_\_\_

SINCE THAT TIME, HAS THE PROBLEM BECOME  BETTER  WORSE  STAYED THE SAME?

HOW DID IT OCCUR? \_\_\_\_\_

DO THE SYMPTOMS CHANGE WITH THE TIME OF DAY? CONSTANT, COMES AND GOES \_\_\_\_\_

LIST ANY VISIBLE BUMPS, SCRAPES, CUTS, ETC. ON YOUR CHILD: \_\_\_\_\_

YES NO

HAS THERE BEEN A CHANGE IN YOUR CHILD'S EATING HABITS? IF SO, WHAT? \_\_\_\_\_

HAS THERE BEEN A CHANGE IN YOUR CHILD'S SLEEPING HABITS? IF SO, WHAT? \_\_\_\_\_

DOES YOUR CHILD CRY IF A PARENT ATTEMPTS TO CHANGE HIS/HER SLEEPING POSITION? \_\_\_\_\_

DOES YOUR CHILD WAKE UP AND CRY FREQUENTLY AT NIGHT? \_\_\_\_\_

ARE THERE ANY OTHER ALTERATIONS OF YOUR CHILD'S NORMAL SLEEP PATTERNS? \_\_\_\_\_

DOES YOUR CHILD HAVE A FEVER OF UNKNOWN ORIGIN? \_\_\_\_\_

DOES YOUR CHILD HAVE A LOSS OF APPETITE OR OTHER RECENT EATING DISORDERS? \_\_\_\_\_

DOES YOUR CHILD HAVE A RECENT CHANGE IN "BATHROOM" HABITS? \_\_\_\_\_

HAS YOUR CHILD RECENTLY BECOME IRRITABLE / RESTLESS / GRUMPY, ETC.? \_\_\_\_\_

### WHAT MAKES THE CONDITION BETTER?

HEAD NECK \_\_\_\_\_

MID BACK \_\_\_\_\_

LOW BACK \_\_\_\_\_

SHOULDER, ARM, HAND \_\_\_\_\_

HIP, LEG, FOOT \_\_\_\_\_

OTHER \_\_\_\_\_

### WHAT MAKES THE CONDITION WORSE?

HEAD NECK \_\_\_\_\_

MID BACK \_\_\_\_\_

LOW BACK \_\_\_\_\_

SHOULDER, ARM, HAND \_\_\_\_\_

HIP, LEG, FOOT \_\_\_\_\_

OTHER \_\_\_\_\_

## PAST MEDICAL HISTORY

YOUR CHILD'S BIRTH:

WAS THE CHILD'S DELIVERY  VAGINAL OR  CESAREAN? \_\_\_\_\_

WAS THE CHILD BORN  HEAD DOWN  BREECH OR  SHOULDER DOWN? \_\_\_\_\_

YES  NO WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED DURING DELIVERY? \_\_\_\_\_

YES  NO WAS LABOR PROLONGED? HOW LONG WAS LABOR? \_\_\_\_\_

YES  NO WAS THERE MORE THAN ONE BABY? \_\_\_\_\_

YES NO

HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE? WHEN? \_\_\_\_\_

DOCTOR'S NAME AND LOCATION: \_\_\_\_\_

FOR WHAT CONDITION? \_\_\_\_\_

HOW MANY TIMES HAVE YOU HAD THIS CONDITION BEFORE?  0-3 TIMES?  4 OR MORE TIMES?

HAS YOUR CHILD EVER SEEN ANYONE ELSE FOR THIS CONDITION? WHEN? \_\_\_\_\_

WHERE TREATED? \_\_\_\_\_ BY WHOM? \_\_\_\_\_

RESULTS: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

YES NO

ALLERGIES? TO WHAT? \_\_\_\_\_

DOES YOUR CHILD TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HAS YOUR CHILD EVER BEEN IN AN AUTOMOBILE ACCIDENT?

WHEN? \_\_\_\_\_ WAS ANYTHING INJURED?  NO  YES, WHAT? \_\_\_\_\_

HOW WAS IT TREATED? \_\_\_\_\_

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_

YES  NO WAS YOUR CHILD RIDING IN A CHILD SEAT? \_\_\_\_\_

WAS THE SEAT IN THE  REAR SEAT  FRONT SEAT, FACING  FORWARD OR  BACKWARD? \_\_\_\_\_

YES  NO WAS YOUR CHILD IN A BOOSTER SEAT? \_\_\_\_\_

YES  NO DOES YOUR CAR HAVE AIR BAGS? \_\_\_\_\_

WAS YOUR VEHICLE STRUCK FROM THE  REAR  FRONT  LEFT SIDE OR  RIGHT SIDE? \_\_\_\_\_

HAS YOUR CHILD EVER HAD ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS OR SURGERIES?

FIRST: WHEN? \_\_\_\_\_ WHAT WAS INJURED? \_\_\_\_\_

HOW WAS IT TREATED? \_\_\_\_\_

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_

SECOND: WHEN? \_\_\_\_\_ WHAT WAS INJURED? \_\_\_\_\_

HOW WAS IT TREATED? \_\_\_\_\_

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) \_\_\_\_\_

HAS YOUR CHILD HAD X-RAYS? WHEN? \_\_\_\_\_ WHAT BODY PARTS? \_\_\_\_\_

### FAMILY HEALTH HISTORY

HEALTH STATUS (IF DECEASED, FROM WHAT?) \_\_\_\_\_

MOTHER: \_\_\_\_\_

FATHER: \_\_\_\_\_

SISTERS: \_\_\_\_\_ HOW MANY \_\_\_\_\_

BROTHERS: \_\_\_\_\_ HOW MANY \_\_\_\_\_

### SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES AND N FOR NO IN EACH OF THE FOLLOWING):

1. ___ EYES	6. ___ URINARY	11. ___ INTERNAL ORGANS
2. ___ EARS, NOSE, MOUTH, THROAT	7. ___ MUSCLES	12. ___ BLOOD
3. ___ HEART	8. ___ NERVES	13. ___ ALLERGIES
4. ___ LUNGS/BREATHING	9. ___ SKIN	14. ___ OTHER _____
5. ___ INTESTINES	10. ___ PSYCHOLOGICAL	

PLEASE DESCRIBE: \_\_\_\_\_

ADDITIONAL CONCERNS/COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

\_\_\_\_\_

\_\_\_\_\_

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

D.C./C.A. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFOR IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULL INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTION, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

## **SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:**

**STROKE-** STROKE IS THE MOST SERIOUS COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY A CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN OCCURS, MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHING THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT 1 PER 400,000 TREATMENTS TO 1 TO 5.85 MILLION TREATMENTS. (CMAJ 2001 OCT. 2; 165 (7):905-6). THE ANNUAL INCIDENCE OF A SPONTANEOUS STROKE IS ESTIMATED AT 1 TO 1.5 PER 100,000 (NEJM, 1994; 330:339-397). THE RESULTS OF A RETROSPECTIVE STUDY CONDUCTED BY HALDEMAN S, ET. AL, SUGGESTED THAT STROKE SHOULD BE CONSIDERED A RANDOM AND UNPREDICTABLE COMPLICATION OF ANY NECK MOVEMENT INCLUDING CERVICAL MANIPULATION (J NEUROL 2002 Aug; 249(8): 1098-104).

**SORENESS-** CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IS IS NOT GENERAL DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

**SOFT TISSUE INJURY-** OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

**RIB INJURY-** MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES CONSIDERED AT RISK. TREATMENT IS PERFORMED CAREFULLY TO MINIMIZE SUCH RISK.

**PHYSICAL THERAPY BURNS-** HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

**OTHER PROBLEMS-** THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS YOUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

**HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE DR. \_\_\_\_\_ AND/OR WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANTS TO EXAMINE, X-RAY AND ADMINISTER CHIROPRACTIC CARE TO MY CHILD AS HE/SHE DEEMS NECESSARY, IN MY PRESENCE OR ABSENCE.**

PATIENT'S NAME PRINTED

TODAY'S DATE

\_\_\_\_\_

\_\_\_\_\_

WITNESS

PARENT OF GUARDIAN SIGNATURE FOR MINOR

\_\_\_\_\_

\_\_\_\_\_