Nedd
Chiropractic & Wellness Center

1221 Cleveland Street
Clearwater, Florida 33755
Phone 727•467•0775
Fax 727•467•0774
www.neddchiro.com

Pediatric Patient History

Child's Name _____ Date of Birth _____
Mother's Name _____ Date of Birth _____
Father's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Mother's Work Phone _____ Mother's Cell _____
Father's Work Phone _____ Father's Cell _____
Email Address _____ Home Phone _____
Referred by: _____ May we send you our email newsletter? ❒ Yes ❒ No
Mother's/Father's Driver's License #: _____
Insurance Carrier _____ Subscriber ID # _____
Subscriber's Name _____ Subscribers' Date of Birth _____

Reason for Today's Visit _____
Age _____ Sex ❒ M ❒ F # of siblings _____
Birth Weight _____ Birth Length _____ Current Weight _____ Current Height _____

Type of Birth: ❒Normal Vaginal ❒Forceps ❒Cesarean
Location: ❒Home ❒Birthing Center ❒Hospital
Problems during pregnancy: _____
_____
Problems during labor/delivery: _____
_____
Infant Feeding: ❒Breast – How Long? _____ ❒Bottle – How Long?_____ Which formula? _____
Number of hours sleeping per night:_____ Quality of Sleep: ❒Good ❒Fair ❒Poor
Water Intake: _____ Typical diet: _____
Exercise: _____
Vitamins/Medication: _____
Vaccination History: _____
Number of prescriptions of antibiotics your child has taken:
During the past 6 months _____ During his/her lifetime _____
Previous Chiropractor: _____
Date of last visit: _____ Purpose: _____
Pediatrician: _____
Past illnesses, surgeries and/or accidents and dates: _____
_____

Family history of illnesses/diseases: _____
_____

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed _____ Date _____

I agree that I am responsible for all fees charged by this office. I authorize release of this information to my insurance carrier. I authorize payment directly to this doctor's office. I authorize a copy of this authorization to be used in place of an original.

Today's Date: _____ Signature: _____

Nedd
Chiropractic & Wellness Center

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments. Also other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, (on me) or on the patient named below, for whom I am legally responsible by the Doctor of Chiropractic named below. And/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other associated office or clinic.

The nature of the chiropractic adjustment
The primary treatment used by Doctors of Chiropractic is the spinal and extremity adjustment. That procedure may be used during your course of care. The Doctor may manually use his hands upon your neck, upper, and/or lower back as well as your extremities in such a way as to move your joints. This may cause you to hear a sound like a "popping" or "cracking" in your neck or back or extremities, much as if you hear when you crack your knuckles. You may feel a sense of movement following the adjustments. The Doctor may also use a hand-held adjusting instrument called an Activator or an electric mechanical adjusting tool called an Adjustor.

The material risk inherent in a chiropractic adjustment
As with any health care procedure, there are certain complications that may arise. Those complications include: fracture, disc injuries, dislocations and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manual manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of the above risks occurring
Fractures are a rare occurrence and generally result from some underlying weakness of the bone that we check for during the taking of your history, and during examination and x-rays. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination that are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

Ancillary Treatment
In addition to a chiropractic adjustment, the following treatment modalities are available at this office and may be part of your treatment plan: massage therapy, cold laser therapy, acupuncture, therapeutic exercise, dietary recommendations, nutritional supplements, myofascial release, heating pads, cold packs, infrared heat, infrared sauna, home exercises, stretching, traction, inversion therapy, electrical muscle therapy, and therapeutic ultrasound.

The availability and nature of other treatment options
Other conventional medical treatment options for your condition include:
- Self-administered, over-the-counter pain killers/anti-inflammatories and rest
- Medical care with prescription drugs such as anti-inflammatory agents, muscle relaxants and pain killers.
- Surgery

The material risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. The purpose of this form as well as the first visit and Report of Findings is to fully inform me of my condition(s), proposed treatment(s), expected benefits, potential harms, and other treatment alternatives so that all of my questions are answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Signature (Or Legal Guardian)_____

Print Patient Name_____ Date_____

Witness to Patient's Signature_____ Date_____

Nedd Chiropractic & Wellness Center ● 1221 Cleveland Street ● Clearwater, Florida 33755
P: (727)467-0775 F: (727)467-0774 ● www.neddchiro.com ● info@neddchiro.com

NEDD CHIROPRACTIC & WELLNESS CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____	_____
Print Patient Name	Date
_____	_____
Print Parent, Guardian or Patient's Legal Representative	Signature of Patient, Parent, Guardian or Patient's Legal Representative.

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release your Protected Health Information (PHI).

_____	_____
_____	_____
_____	_____