WELCOME TO NORMAN FAMILY CHIROPRACTIC

CHILD HISTORY FORM

Child's Name:	**Age:**	**Date of Birth:**
Parent Guardian Names:		
Address: (Street, City, State & Zip)		
Phone: (Home)	**(Work)**	**(Cell)**
Email Address:		
Sex: □ **Male** □ **Female**	**Height:**	**Weight:**
How many siblings?		
Names & Ages of Siblings:		
Referred to Dr. Norman by:		
Purpose for visit:		
Has child been treated by any other doctor for purpose of visit?		
If yes, describe treatment given:		

Check any conditions your child has suffered from:

- □ **Ear Infections**
- □ **Chronic Colds**
- □ **Asthma**
- □ **Recurring Fevers**
- □ **Sports Injury**
- □ **Temper Tantrums**
- □ **Scoliosis**
- □ **Allergies**
- □ **Bed Wetting**
- □ **Growing Pains**
- □ **Digestive Problems**
- □ **Difficulty Sleeping**
- □ **ADD/ADHD**
- □ **Car Accident**
- □ **Colic**
- □ **Seizures**
- □ **Diabetes**
- □ **Slow Mental Development**
- □ **Slow Physical Development**
- □ **Other** ____________________

Please list any and all traumas or injuries child has experienced:

___

___

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Please list and describe any surgeries your child has had:

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Has your child fallen from a high place?
Number of medications or Antibiotics child has taken in past year: Lifetime:
List any and all medications child is taking currently, including OTC:
Describe child's normal diet on a daily basis:
Describe child's physical activity – type and how often:

Prenatal & Birth History:

Complications during pregnancy? □ Yes □ No If yes, please describe:
Ultrasounds during pregnancy? □ Yes □ No If yes, how many? Which months?
Any medications taken before or during delivery?
Alcohol/Cigarettes/Drugs during pregnancy? □ Yes □ No Was your baby full-term?
Location of Birth: □ Hospital □ Home □ Birthing Center How long was labor?
Interventions: □ Epidural □ Forceps □ Vacuum Extraction □ VBAC □ Planned C-Section □ Emergency C-Section
Any complications with delivery?
Has child had vaccines? □ Yes □ No Was there any adverse reactions?

Authorization of Chiropractic Care for a Minor

I hereby authorize Dr. Norman at Norman Family Chiropractic & Wellness to administer care to my child as he deems necessary. I clearly understand and agree, and I am personally responsible for payment of all fees charged by this office.

X ______________________________ ______________________

Signature **Date**

INFORMED CONSENT TO TREATMENT

In an effort to encourage and support a shared decision making process between us regarding your health needs, Norman Family Chiropractic provides the following information:

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is/are misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

1. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.
2. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE THESE RISKS

I hereby consent to the chiropractic treatment as indicated, needed and explained to me. If during the course of treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatment as may be indicated by sound and prudent chiropractic practice.

No guarantee or warranty has been offered to me that results will be to my complete satisfaction.

IF YOU HAVE ANY QUESTIONS ABOUT THIS, PLEASE ASK YOUR CHIROPRACTOR.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

Signature: ____________________________________ Date: _____________________________

Witness: ____________________________________ Date: _____________________________

Norman Family Chiropractic

Please Sign All That Apply

PREGNANCY RELEASE (ALL WOMEN)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: ______________________________

_____________________________________ ______________________

Patient Signature **Date**

CONSENT TO EVALUATE / ADJUST A MINOR CHILD

I, ___________________________, being the parent or legal guardian of ___________________________ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive examination and chiropractic care as deemed necessary.

_____________________________________ ______________________

Patient Signature **Date**

CONSENT TO X-RAY

I hereby authorize Norman Family Chiropractic & Wellness, or whoever the clinician may designate to take x-rays.

_____________________________________ ______________________

Patient Signature **Date**

PRIVACY NOTICE

The practice may use and/or disclose my protected health information in order for the practice to treat me and obtain payment for that treatment and as necessary for the practice to conduct its specific health care operations. I understand that the practice utilizes an open adjusting room format to conduct patient treatment.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____________________________________ ______________________

Patient Signature **Date**

KID'S HEALTH ASSESSMENT: ***NAME: …………………………………….*** ***Today's Date: _ _ / _ _ / _ _ _ _***

This questionnaire assists you to "quantify" your child's state of health: Read each description and tick inside the box which most closely corresponds to how you feel about each one in both regularity and severity sections. (You will have two ticks in each row next to each description, one for regularity and one for severity.)

	REGULARITY					**SEVERITY**				
	Never	**Rarely**	**Someti mes**	**Often**	**Always**	**None**	**Mild**	**Moderat e**	**Severe**	**Unbear able**
Angry, frustrated and/or tantrums										
Argues with siblings and/or friends										
Asthma, cough or breathing problems										
Behavioral problems										
Complains of aches and pains										
Concentration problems										
Dislikes after-school activities										
Headaches										
Health affects family activities										
Infections										
Learning problems										
Low energy										
Misses school when ill										
Misses sport/ recreation when ill										
Nausea, sick feelings in tummy										
Pains in feet and/or legs										
Pains in hands and/or arms										
Require bed rest during day when ill										
Sad, depressed, unhappy or upset										
Sick/Unwell										
Taking over the counter medication/s										
Taking prescription medication/s										
Tummy or abdominal pains or problems										
Unhappy at home &/or school										
Vomiting, constipation or diarrhea										
Multiply # in each column	0	1X _ =	2X _ =	3X _ =	4X _ =	0	1X _ =	2X _ =	3X _ =	4X _ =
SUBTOTAL										
TOTAL										

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