



**BALANCE**  
CHIROPRACTIC

## PEDIATRIC HEALTH HISTORY

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Parent's/Guardians' Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Parent's Email: \_\_\_\_\_  
Parent's Cell Phone: \_\_\_\_\_ May we leave a message? Yes No  
Parent's Work Phone: \_\_\_\_\_ May we leave a message? Yes No  
Siblings and ages: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Has your child ever been under Chiropractic Care? ☐ Yes ☐ No

### Emergency Contact

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Alternative phone number: \_\_\_\_\_

### Family Doctor

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_  
May we communicate with your family doctor regarding your child's care if necessary? Yes No

### Why have you decided to have your child evaluated by a Chiropractor?

- ☐ He/She is continuing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

### Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_  
Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_  
Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

## What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Infections	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Slow or Absent Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Asymmetrical Crawling/Gait
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Challenges
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent sickness	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Concentration Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Torticollis/Head Tilt	<input type="checkbox"/>	<input type="checkbox"/>	Tie Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Trouble feeding on one side	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Issues
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Red, Swollen, Painful Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tremors/ Ticks
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Crying	<input type="checkbox"/>	<input type="checkbox"/>	Autism

Do you have a specific concern that brings you in?

- ☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.
- ☐ Yes: \_\_\_\_\_

*If yes, please answer the following questions:*

Does your child appear to be in pain or discomfort? \_\_\_\_\_ When did it start? \_\_\_\_\_

Is it getting better, worse, or staying the same? \_\_\_\_\_ Suddenly or gradually? \_\_\_\_\_

Have you seen other health professionals regarding this complaint? ☐ Yes ☐ No

If Yes, Whom? \_\_\_\_\_

What treatment did they use? \_\_\_\_\_

Has your child taken any medication for this complaint? ☐ No ☐ Yes: \_\_\_\_\_

Has your child ever experienced this complaint before? ☐ No ☐ Yes: \_\_\_\_\_

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: \_\_\_\_\_

### Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center Other: \_\_\_\_\_

Medications during labor/delivery (including IV antibiotics): ☐ No ☐ Yes: \_\_\_\_\_

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Was your child at any time during pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? ☐ Vaginal ☐ C-Section: Planned or emergency?

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other: \_\_\_\_\_

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: \_\_\_\_\_

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes: \_\_\_\_\_

Any concerns about misshapen head at birth? ☐ No ☐ Yes



## Post Natal & Infant History

How many weeks gestation was the baby at birth? \_\_\_\_\_ Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Was the baby ever admitted to the NICU? ☐ No ☐ Yes

If yes, for how long and why? \_\_\_\_\_

Were there any medications given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? \_\_\_\_\_

Was your child exclusively breastfed? ☐ No ☐ Yes: How many months: \_\_\_\_\_

Was your child breastfed + formula fed? ☐ No ☐ Yes: How many months: \_\_\_\_\_

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

Has your child been vaccinated? ☐ No ☐ Yes

If yes, ☐ Full ☐ Partial ☐ Delayed ☐ Other: \_\_\_\_\_

Did your child have any reactions to vaccines? ☐ No ☐ Yes: \_\_\_\_\_

## Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes

Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes

Has your child broken any bones? ☐ No ☐ Yes

Has your child had any previous hospitalizations? ☐ No ☐ Yes

Has your child had any previous surgeries? ☐ No ☐ Yes

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly

Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly

## Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No: \_\_\_\_\_

Emotionally: ☐ Yes ☐ No: \_\_\_\_\_

Physically: ☐ Yes ☐ No: \_\_\_\_\_

What is your primary goal for your child in this office?

Our goals are to provide a detailed assessment of your child's current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

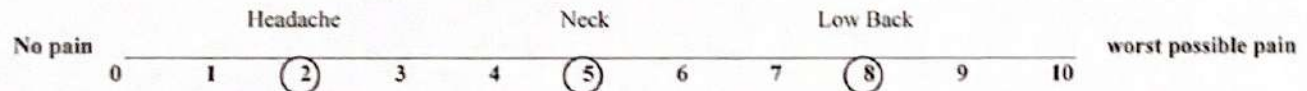
Date \_\_\_\_\_

Please read carefully:

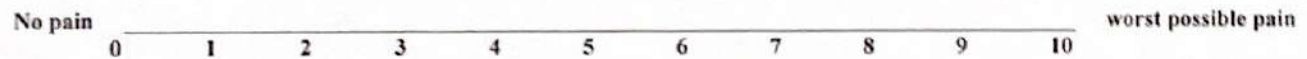
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**



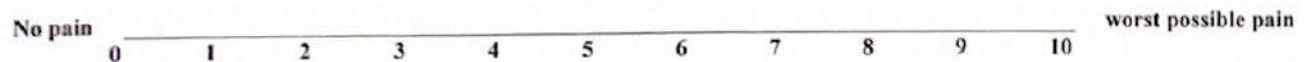
1 – What is your pain RIGHT NOW?



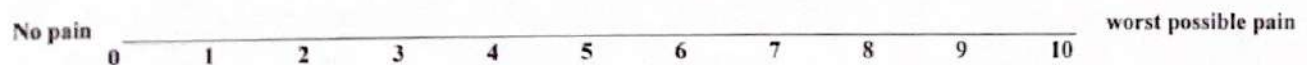
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care. Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION  
FOR THEIR REVIEW.

DATE \_\_\_\_\_

PLEASE PRINT YOUR NAME HERE \_\_\_\_\_

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					



Practice Member Information (Must be Completed before Services Can Be Rendered)

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

PHONE: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_ Phone #: \_\_\_\_\_

**NAME OF PRIMARY INSURANCE CARRIER:** \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured Social Security Number: \_\_\_\_\_

**NAME OF SECONDARY INSURANCE CARRIER:** \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insured Social Security Number: \_\_\_\_\_

Insurance Policies and Fee Schedule

- **Consultation**-includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)**- includes one or more of the following: thermography, surface electromyography, range of motion, motion and /or static palpation, leg checks \$50-\$75.
- **Chiropractic Adjustment**- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$40-\$60.
- **X-Rays**-Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can be used to indicate progress after a period of care. \$50 per view.
- 

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Erin Magee, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## **INFORMED CONSENT FOR CHIROPRACTIC CARE**

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

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I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

---

PRINT PATIENT'S NAME HERE

---

PATIENT'S SIGNATURE

---

DATE

**IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW**

### **WRITTEN CONSENT FOR A CHILD**

NAME OF PATIENT WHO IS A MINOR/CHILD \_\_\_\_\_

I AUTHORIZE DR. ERIN MAGEE AND ANY AND ALL BALANCE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY BALANCE CHIROPRACTIC.

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DATE

---

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD

---

WITNESS SIGNATURE (OFFICE STAFF)

---

DATE



### Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedures applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

### ***Notice of Privacy Practices Acknowledgement***

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- 2. Obtain payment from third-party payers.
- 3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



## X-RAY AUTHORIZATION FOR MINOR/CHILD

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS; WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS AND VIDEO FLUOROSCOPY STUDY ON A DISC IS \$20.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON AND REGULAR PRACTICE HOUR DAYS.

**PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS.

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF PROVIDENCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVISE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

\_\_\_\_\_  
PRINT PATIENT'S NAME HERE

\_\_\_\_\_  
PATIENT'S DATE OF BIRTH

\_\_\_\_\_  
GUARDIAN SIGNATURE & RELATIONSHIP TO CHILD/MINOR

\_\_\_\_\_  
DATE

**ADOLESCENT FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE SHE IS NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT PROVIDENCE CHIROPRACTIC.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE**

Sex: ☐ M ☐ F

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