INVICTUS CHIROPRACTIC

TEAM MEMBERS ONLY

Today's Date: _____-_____-_____

PM File Number: _____

Pediatric Practice Member Application

PATIENT DEMOGRAPHICS

Child's Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ DOB_____-_____-_____ Mother's Phone: _____

Father's Name: _____ DOB _____-_____-_____Father's Phone: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Pediatrician/Family MD _____City _____ State _____

Last Visit_____-_____-_____ Reason for visit:_____

Whom may we thank for referring your child to this office? _____

HISTORY OF CURRENT HEALTH CONCERNS

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

*If your child is experiencing **Pain/Discomfort, please identify where and for how long:***

_____

_____

1. **When did the** Problem first begin? Date _____-_____-_____ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? ☐ No ☐ Yes If yes, describe:

   _____
4. Have you seen any **other doctors** for this problem? ☐ No ☐ Yes If yes, who? □ Chiropractor □ MD □ Other_____

   When?_____ Results?_____
5. How long ago? _____Days _____Weeks _____Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW?:** ☐ Rapidly Improving ☐ Slowly Improving ☐ About the Same ☐ Gradually Worsening ☐ On & Off
8. Please list any **medication taken** for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes If yes, please explain:

   _____

   _____
10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes If yes, please explain:

    _____

    _____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

			FALL FROM:
☐ ADD/ADHD	☐ Digestive Disorders	☐ Orthopedic Problems	☐ **Baby Walker**
☐ Anemia	☐ Dizziness	☐ Poor Appetite	☐ **Bed/Couch/Furniture**
☐ Arm/Hand Problems	☐ Ear Infections/Aches	☐ Poor Posture	☐ **Bicycle**
☐ Asthma	☐ Fainting	☐ Reflux	☐ **Changing Table**
☐ Back Aches	☐ Growing Pains	☐ Ruptures/Hernia	☐ **Crib**
☐ Bed Wetting	☐ Headaches	☐ Scoliosis	☐ **High Chair**
☐ Behavioral Problems	☐ Heart Trouble	☐ Seizures/Convulsions	☐ **Monkey Bars/Playground**
☐ Broken Bones	☐ Hypertension	☐ Sinus Trouble	☐ **Skateboard/Skates**
☐ Colds/Flu	☐ Joint Problems	☐ Sleeping Problems	☐ **Slide**
☐ Colic	☐ Leg/Foot Problems	☐ Stomach Aches	☐ **Stairs**
☐ Constipation	☐ Muscle Pain	☐ Walking Trouble	☐ **Swing**
☐ Diarrhea	☐ Neck Problems		

☐ Allergies to: _____

☐ Other: _____

PREGNANCY INFORMATION

How was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy?_____

Other information: _____

DELIVERY INFORMATION

Birth Intervention: Forceps Vacuum Extraction Caesarian Section

_____

Induced? Yes/No Explain: _____

Medications during delivery?_____

Other information: _____

POST-BIRTH INFORMATION

Birth Weight:_____ Birth Length: _____

Breast Fed: Yes/No How long?_____ Formula Fed Yes/No How Long?_____

Introduced Solid Foods at _____ Months

Food Allergies or intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____ Total lifetime _____

Present prescription drugs/ dosage?_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years: _____

_____

Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe: _____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

Back pain **Headaches**

0 1 2 (3) 4 5 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>best</u>? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>worst</u>? _____%

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	**EFFECT:**			
Holding Head Up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Tummy Time	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Nursing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting Up	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Crawling	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Getting Dressed	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing with Friends	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other:_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

LIST ANY OTHER RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

CHILD/MINOR INFORMED CONSENT FOR CHIROPRACTIC CARE

For A Child/Minor, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Jordan Carroll and any and all Invictus Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Invictus Chiropractic.

Guardian Signature: _____ Date: _____ - _____ - _____

Relationship to Child/Minor: _____

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 (HIPPA). 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 physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose 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.

_____ _____ - _____ - _____
Practice Member Signature **Date Completed**

X-RAY AUTHORIZATION

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. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Invictus Chiropractic does 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 advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____ - _____ - _____
Practice Member Printed Name **Date of Birth**

_____ _____ - _____ - _____
Practice Member Signature **Date Completed**