Priestley Family Chiropractic

Specializing in Pediatric Development and Adult Health

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ☐ M ☐ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ☐ Yes ☐ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia ☐ Strep B ☐ Nauseau/Vomitting
☐ Pre-Term ☐ Fatigue ☐ Swelling ☐ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal / Vaginal ☐ Breech
☐ Cesarean ☐ Scheduled/Induced ☐ Epidural

Problems during labor / delivery? _____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice ☐ Meconium
☐ Respiratory Distress ☐ Extended Hospitalization ☐ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

☐ Chicken Pox ☐ Measles ☐ Rubeola

☐ Mumps ☐ Rubella ☐ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

☐ Allergies ☐ Broken Bones ☐ Digestive Issues (constipation/diarrhea) ☐ Hypertension ☐ Orthopedic Problems

☐ Anemia ☐ Chronic Ear Aches ☐ Jeuvenile Rheumatroid Arthritis ☐ Paralysis

☐ Arm Problems ☐ Colds/Flu ☐ Dizziness ☐ Poor Appetite

☐ Asthma ☐ Colic ☐ Fainting ☐ Joint Problems ☐ Ruptures/Hernias

☐ Back Aches ☐ Convulsions/Seizures ☐ Headaches ☐ Leg Problems ☐ Sinus Trouble

☐ Bed Wetting ☐ Delayed Speech ☐ Heart Trouble ☐ Neck Problems ☐ Tuberculosis

☐ Behavioral Problems ☐ Diabetes ☐ Hyperactivity ☐ Neuritis ☐ Walking Problems

Have you vaccinated your child?

☐ No ☐ Yes ☐ As scheduled ☐ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____ Number of pregnancies: _____

Children's' Ages: _____ Are you currently pregnant? ☐ No ☐ Yes, I'm due: _____

Childrens' health concerns: _____ Health concerns regarding this pregnancy? _____

INSURANCE INFORMATION

We will be happy to verify your insurance benefits and find out if you have any chiropractic coverage. However, we do collect payment in full for services rendered on the 1st visit.

Do you have insurance you would like to submit? Yes ☐ No ☐

I hereby authorize the doctor to release all information regarding my records if needed. Initials _____

I understand that I am financially responsible for all charges. Initials _____

History of Birth

Hospital / Birthing Center: ☐ Home ☐ Medical ☐ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? ☐Yes ☐No If yes, how? ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced Labour

Were medications given to the mother at birth? ☐Yes ☐No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? ☐No ☐Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? ☐Yes ☐No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? ____ Do his/her sleeping patterns seem normal? ☐Yes ☐No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

_____

The father's side? _____

Do the child's siblings have any health problems? ☐Yes ☐No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke ☐Yes ☐No 2. Drink alcohol? ☐Yes ☐No 3. Take supplements/vitamins? ☐Yes ☐No

4. Take drugs? ☐Yes ☐No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? ☐Yes ☐No If yes, how many? _____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? ☐Yes ☐No

Was your child breast fed? ☐Yes ☐No If yes, for how long? _____ ☐ weeks ☐ months ☐ years

At what **age** was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? ☐Yes ☐No If yes, which ones? _____ Did your child react to them? ☐Yes ☐No

Has your child had antibiotics? ☐Yes ☐No If yes, how many courses has the child had so far & why? _____

Any pets at home? ☐Yes ☐No Any smokers at home? ☐Yes ☐No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? ☐Yes ☐No Any problems bonding? ☐Yes ☐No Does your child seem normal to you? ☐Yes ☐No

Does the child have any behaviour problems? ☐Yes ☐No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? ☐Yes ☐No If yes, specify: _____

Did your child go to daycare? ☐Yes ☐No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? ☐Bruises ☐Odd shaped head ☐Stuck in birth canal ☐Fast and/or excessively long birth

☐Respiratory Depression ☐Cord around neck ☐Other _____

Any falls/accidents during pregnancy? ☐Yes ☐No Has the child had any major falls since birth? ☐Yes ☐No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? ☐Yes ☐No Please explain: _____

Does your child play sports? ☐Yes ☐No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx. Hours spent at play per week? _____ hrs

Informed Consent to Chiropractic Care

Patient: Please discuss any questions or concerns with the doctor and/ or associates.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by the doctor, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor will look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bares the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. 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 (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____ Printed Name of Patient

_____ Printed Name of Parent

_____ Signature of Parent

_____ Date

Submit by Emailing