APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name _____ Name he/she goes by _____
Name of Parents/Guardians _____
How did you hear about our office? _____

1. What are your health goals? Please rank them in order of priority.

A) _____
B) _____
C) _____

WELLNESS COMMITMENT

At Apol Chiropractic , we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are closest to your personal health goal(s):

○ Restore health ○ Increase wellness ○ Improved performance ○ Symptom of temporary relief

FAMILY HEALTH HISTORY

Address City, State, Zip _____
Home Phone _____ Parent's Work Phone _____ Cell Phone _____
Email Address _____
Birth Date M/D/Y _____ Sex Check ○ M ○ F Weight _____ Height _____
Past or present health problems of parents & siblings _____

HEALTH HISTORY

Subluxations are a condition of the spine that Chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, dietary, and environmental stressors that lead to subluxations. Help us identify yours.

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Previous Chiropractor _____ Date of last visit & reason _____

Were spinal maintenance programs given to your child to maximize the stability of his/her spine? O No O Yes
Are other family members under chiropractic care? O No O Yes, who? _____
Name of Pediatrician _____ Date of last visit & reason _____

Are you satisfied with the care your child received there? O No O Yes

PRENATAL HISTORY Check applicable

Location & type of Birth Attendant O Home O Birthing Center O Hospital O OBGYN O Midwife
Complications during pregnancy O No O Yes, list _____

Ultrasounds during pregnancy: O No O Yes, how many? _____
Birth intervention: O Forceps O Vacuum
Caesarian: O Planned O Emergency, complications? O No O Yes, explain _____

Medications during pregnancy/delivery? O No O Yes, list: _____

Birth weight: _____ Birth length: _____ APGAR scores?: _____
Breast Fed: O No O Yes, how long? _____ Formula fed: O No O Yes, how long? _____
Cow's milk at: _____ months Solids at: _____ months, did he/she have teeth at the time? _____
Food/juice allergies or intolerances: O No O Yes, what? _____
Anything else that needs to be noted _____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? O Yes O No, please explain _____
At what age did the child? Respond to sound _____ Follow an object _____ Hold up head _____
Vocalize _____ Sit alone _____ Crawl _____ Walk _____
Do you consider your child's sleeping pattern normal? O No O Yes. Number of hours sleeping per night: _____
Quality of sleep: O Good O Fair O Poor

VACCINATION HISTORY

Any complications such as excessive crying, fevers, convulsions, loss of development _____

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CHILDHOOD DISEASES

Chicken Pox ○ No ○ Yes, age _____ Mumps ○ No ○ Yes, age _____

Whooping cough ○ No ○ Yes, age _____ Rubella ○ No ○ Yes, age _____

Other _____, age _____ Other _____, age _____

Many patients are surprised to find out that chiropractic care can help many of the conditions listed next, feel free to ask how your child's condition may also be affecting his/her complaints.

Has your child ever suffered from Check all that apply

○ Asthma	○ Blood disorders	○ Acid Reflux	○ Arm problems	○ Diabetes	○ Ruptures/Hernias
○ Fatigue	○ Neck problems	○ Convulsions	○ Sore throats	○ Dizziness	○ Shortness of Breath
○ Arthritis	○ Poor Appetite	○ Back aches	○ Leg problems	○ Irritability	○ Urinary problems
○ Anemia	○ Growing pains	○ Headaches	○ Loss of smell	○ Colds/Flu	○ Digestive problems
○ Fainting	○ Stomach aches	○ Constipation	○ Muscle cramps	○ Depression	○ Chronic Ear aches
○ Allergies	○ Muscle jerking	○ Hypertension	○ Heart problems	○ Behavioral	○ Poor coordination
○ Diarrhea	○ Loss of balance	○ ADD/ADHD	○ Broken bones	○ Bronchitis	○ Walking problems
○ Epilepsy	○ Joint problems	○ Bed Wetting	○ Sinus problems		

PHYSICAL STRESS

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of your child's.

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Is this the case with your child? ○ No ○ Yes

When was your child's most recent fall? ○ No ○ Yes, what happened? _____

Which sports has your child practiced? Check all that apply ○ Soccer ○ Gymnastics ○ Football ○ Cheerleading ○ Basketball ○ Horseback ○ Baseball ○ Martial Arts ○ Other _____

Have your child ever? Check all that apply ○ Had a sports injury ○ Slipped/Fell on the ground (or ice) ○ Fallen down the stairs

Broken a bone, if so which? _____

Has your child ever been involved in a car accident? ○ No ○ Yes, was there impact? ○ No ○ Yes, were there injuries? No

If yes, list dates/any treatment _____

Has your child ever been seen on an emergency basis? ○ No ○ Yes, please list all _____

Other traumas not described above? ○ No ○ Yes, please list all _____

Prior surgery: ○ No ○ Yes, type and date: _____

Menses: ○ No ○ Yes, age of start _____

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ENVIRONMENTAL STRESS Check applicable

Number of antibiotics your child has taken: Past 6 months _____ Total during his/her lifetime _____

Drugs your child is taking including prescription and non-prescription drugs Check all that apply

O Tylenol/Advil O Cold tablets
O Anti-Depressants O Allergy O ADHD O Asthma O Painkillers
O Other _____

Does your child take any Vitamins or Herbs? O No O Yes, what? _____

Does your child take any Vitamins or Herbs? O No O Yes, are they: O Synthetic O Food based

Does somebody in the household smoke? O No O Yes

Does your child: O Drink Soda O Use vitamins O Drink Bottled water O Exercise regularly
O Watch more than 5 hours of TV a week O Spend 1 or more hours on a computer daily

EMOTIONAL STRESS

What does your child do for stress relief? _____

How many times a week does your child exercise? _____

Sleep Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
Mindset Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
Personal relationships Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
School Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress

Are there any other health habits that you could share with us? _____

GLUTEN QUESTIONNAIRE

Gluten intolerance has been found to be most common among people of Irish, English, Scottish and Scandinavian, and Eastern European. Often times it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process, which affects an alarming percentage of the population. The most significant symptoms are weight gain, fatigue and depression. The following test is a diagnostic tool to help you to understand the symptoms and signs that are likely to go along with gluten intolerance.

1. Do any of the following apply to your child? Check all that apply.

O Overly sensitive to physical & emotional pain, cry easily
O Muscle or joint pain or stiffness of unknown cause
O Difficulty relaxing, feel tense frequently
O Tendency to over consume alcohol
O Tendency to overeat sweets, bread, carbs
O Cravings for sweets, bread, carbohydrates
O Female hormone imbalance (PMS, menopausal symptoms)
O Weight gain
O Difficulty gaining weight
O Unexplained fatigue
O Eat when upset, eat to relax
O Migraine like headache
O Abdominal pain / cramping
O "Love" specific foods
O Food allergies / sensitivities
O Difficulty digesting dairy products
O Unexplained digestive problems
O Intestinal gas
O Constipation / diarrhea of no known cause
O Abdominal bloating or distention
O Unexplained skin problems/rashes

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2. Has your child suffered from any of the following conditions?

- ○ Allergies
- ○ Irritable bowel syndrome
- ○ Bulimia
- ○ Iron deficiency / anemia
- ○ Osteoporosis / bone loss
- ○ Chronic fatigue
- ○ Anorexia
- ○ Ulcerative colitis
- ○ Candida
- ○ Lactose intolerance
- ○ Depression
- ○ Crohn's disease
- ○ Rosacea
- ○ Diabetes
- ○ Hypoglycemia

Scoring:

Count the number of **checked** ("yes") responses = _____

If your score is **4 or Less**, your child's potential for gluten intolerance is: **Not likely**

If your score is between **5 thru 8**, your child's potential for gluten intolerance is: **Suspected**

If your score is **9 or more**, your child's potential for gluten intolerance is: **Very likely**

CONSULTATION

If this is from an *auto or school related accident* please STOP and ask for an additional form.

If the reason you are seeking chiropractic care for your child is pain based, please fill out.

Briefly state the reason you are seeking chiropractic care _____

Severity of his/her main complaint (at its worst) Circle one. Low 1 2 3 4 5 6 7 8 9 10 Extreme

Describe your child's pain Check one ○ Constant ○ Occasional ○ Dull ○ Frequent ○ With motion ○ Intermittent ○ Sharp ○ Throbbing ○ Achy ○ Burning ○ Numbness

Pain Radiates? ○ No ○ Yes, where _____

Worse in: Check applicable ○ Mornings ○ Evenings ○ When sitting ○ Standing ○ Always

Anything not listed above that makes it worse? _____

Better in: Check applicable ○ Mornings ○ Evenings ○ When sitting ○ Standing ○ Always the Same

Anything not listed above that makes it better? _____

Ever had pain in this area before: ○ No ○ Yes, when _____

Was the injury due to accident? ○ No ○ Yes, date of injury M/D/Y _____

What type of accident was it? ○ Auto ○ Home ○ Fall ○ Other,what happend? _____

Is his/her condition getting worse? ○ No ○ Yes, how _____

Does it interfere with your child's ○ School ○ Sleep ○ Daily routine ○ Exercise

Have you lost time from school because of it? ○ No ○ Yes, what dates? _____

Does he/she have pain and/or difficulty performing any of the following activities: Check all that apply

- ○ Concentrating ○ Sleeping ○ Lifting ○ School ○ Recreation
- ○ Personal care ○ Walking ○ Reading ○ Sitting ○ Standing

Does your child sleep on their stomach? ○ No ○ Yes Sometimes.

Is there any other injury to your child's spine, minor or major, that the Doctor should know about? _____

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Other professionals seen for this condition? _____

Results with treatment? _____

List any past surgeries and dates _____

_____

_____

Other Health Problems or Complaints you would like to address _____

_____

_____

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SIGNS & SYMPTOMS	When (check one or both)		Severity (check one)			Comment
Mood swings	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Anxiety/Nervousness/Irritable (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Overly Reactive/Short fuse/Anger (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Low Mood/Depression (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Low Blood Sugar/High Blood Sugar	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Lowered self-esteem/self-image (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Care for others before yourself	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Sadness/Crying (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Trouble Concentrating	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Memory difficulties	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Fatigue/Anemia (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Increased Appetite/Constant hunger (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Sweet cravings/Carbs/Chocolate (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Caffeine/Stimulant cravings (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Salt cravings	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Headaches/Migraines (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Muscle Pain/Joint Aches/Backache (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Weight gain/Trouble Losing Weight (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Weight loss	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Water Retention	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Bloating/Belching/Gas (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Stomach Burning/Nausea/Indigestion (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Constipation	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Light colored stool	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Loose stool/Diarrhea/IBS (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Acne/Rashes/Brown Spots (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Excessive facial hair/body hair (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Body/Head hair loss (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Infertility	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Lowered libido/Heightened libido (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Hot flashes/Night Sweats (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Palpitations	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Breast tenderness/Breast cysts (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Nipple discharge	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Vaginal infections/Yeast infections (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Urinary Frequency/Incontinence/Infections (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Dry eyes/Dry skin/Overall dryness (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Changes to Labia/Clitoral tissue (atrophy, thinning, itching, discoloration, burning) (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Vaginal changes (dryness, tearing, decreasing size) (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Other	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	

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SYMPTOM SURVEY

Only check symptoms that apply. MILD = occurs rarely, MODERATE = occurs several times a month, SEVERE = constant

A	Acid foods upset	○ Mild	○ Moderate	○ Severe	Strong light irritates	○ Mild	○ Moderate	○ Severe
	Get chilled, often	○ Mild	○ Moderate	○ Severe	Urine amount reduced	○ Mild	○ Moderate	○ Severe
	"Lump" in throat	○ Mild	○ Moderate	○ Severe	Heart pounds after retiring	○ Mild	○ Moderate	○ Severe
	Dry mouth-eyes-nose	○ Mild	○ Moderate	○ Severe	"Nervous" stomach	○ Mild	○ Moderate	○ Severe
	Pulse speeds after meals	○ Mild	○ Moderate	○ Severe	Appetite reduced	○ Mild	○ Moderate	○ Severe
	Keyed up - fail to calm	○ Mild	○ Moderate	○ Severe	Cold sweats often	○ Mild	○ Moderate	○ Severe
	Cuts heal slowly	○ Mild	○ Moderate	○ Severe	Fever easily raised	○ Mild	○ Moderate	○ Severe
	Gag Easily	○ Mild	○ Moderate	○ Severe	Neuralgia-like pains	○ Mild	○ Moderate	○ Severe
	Unable to relax, startles easily	○ Mild	○ Moderate	○ Severe	Staring, blinks little	○ Mild	○ Moderate	○ Severe
	Extremities cold, clammy	○ Mild	○ Moderate	○ Severe	Sour stomach frequent	○ Mild	○ Moderate	○ Severe
B	Joint stiffness after arising	○ Mild	○ Moderate	○ Severe	Breathing irregular	○ Mild	○ Moderate	○ Severe
	Muscle-leg-toe cramps at night	○ Mild	○ Moderate	○ Severe	Pulse slow; feels "irregular"	○ Mild	○ Moderate	○ Severe
	"Butterfly" stomach, cramps	○ Mild	○ Moderate	○ Severe	Gagging reflex slow	○ Mild	○ Moderate	○ Severe
	Eyes or nose watery	○ Mild	○ Moderate	○ Severe	Difficulty swallowing	○ Mild	○ Moderate	○ Severe
	Eyes blink often	○ Mild	○ Moderate	○ Severe	Constipation/diarrhea alternating	○ Mild	○ Moderate	○ Severe
	Eyelids swollen, puffy	○ Mild	○ Moderate	○ Severe	"Slow starter"	○ Mild	○ Moderate	○ Severe
	Indigestion soon after meals	○ Mild	○ Moderate	○ Severe	Gets "chilled" infrequently	○ Mild	○ Moderate	○ Severe
	Always hungry; "lightheaded" often	○ Mild	○ Moderate	○ Severe	Perspire easily	○ Mild	○ Moderate	○ Severe
	Digestion rapid	○ Mild	○ Moderate	○ Severe	Circulation poor, sensitive to cold	○ Mild	○ Moderate	○ Severe
	Vomiting frequent	○ Mild	○ Moderate	○ Severe	Subject to colds, asthma, bronchitis	○ Mild	○ Moderate	○ Severe
	Hoarseness frequent	○ Mild	○ Moderate	○ Severe				
C	Eat when nervous	○ Mild	○ Moderate	○ Severe	Heart palpitates if meals delayed	○ Mild	○ Moderate	○ Severe
	Excessive appetite	○ Mild	○ Moderate	○ Severe	Afternoon headaches	○ Mild	○ Moderate	○ Severe
	Hungry between meals	○ Mild	○ Moderate	○ Severe	Overeating sweets upsets	○ Mild	○ Moderate	○ Severe
	Irritable before meals	○ Mild	○ Moderate	○ Severe	Sleeping few hrs; difficulty falling asleep	○ Mild	○ Moderate	○ Severe
	Get "shaky" if hungry	○ Mild	○ Moderate	○ Severe	Crave candy or coffee in afternoons	○ Mild	○ Moderate	○ Severe
	Fatigue, eating relieves	○ Mild	○ Moderate	○ Severe	Depression moods: "blues"/melancholy	○ Mild	○ Moderate	○ Severe
	"Lightheaded" if meals delayed	○ Mild	○ Moderate	○ Severe	Abnormal craving for sweets/snacks	○ Mild	○ Moderate	○ Severe
D	Hands/feet go to sleep, numbness	○ Mild	○ Moderate	○ Severe	Muscle cramps worse in exercise/"charley horses"	○ Mild	○ Moderate	○ Severe
	Sigh frequently, "air hunger"	○ Mild	○ Moderate	○ Severe	Shortness of breath worse on exertion	○ Mild	○ Moderate	○ Severe
	Aware of "breathing heavily"	○ Mild	○ Moderate	○ Severe	Dull pain in chest/left arm, worse on exertion	○ Mild	○ Moderate	○ Severe
	High altitude discomfort	○ Mild	○ Moderate	○ Severe	Bruise easily, "black and blue" spots	○ Mild	○ Moderate	○ Severe
	Opens windows in closed room	○ Mild	○ Moderate	○ Severe	Tendency to anemia	○ Mild	○ Moderate	○ Severe
	Susceptible to colds and fevers	○ Mild	○ Moderate	○ Severe	"Nose bleeds" frequent	○ Mild	○ Moderate	○ Severe
	Afternoon "yawner"	○ Mild	○ Moderate	○ Severe	Noises in head or "ringing in ears"	○ Mild	○ Moderate	○ Severe
	Get "drowsy" often	○ Mild	○ Moderate	○ Severe	Breastbone "tightness" on exertion	○ Mild	○ Moderate	○ Severe
	Swollen ankles worse at night	○ Mild	○ Moderate	○ Severe				

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E	Dizziness	○ Mild	○ Moderate	○ Severe	Skin peels on foot soles	○ Mild	○ Moderate	○ Severe
	Dry skin	○ Mild	○ Moderate	○ Severe	Pain between shoulder blades	○ Mild	○ Moderate	○ Severe
	Burning feet	○ Mild	○ Moderate	○ Severe	Use laxatives	○ Mild	○ Moderate	○ Severe
	Blurred vision	○ Mild	○ Moderate	○ Severe	Stools alternate from soft to watery	○ Mild	○ Moderate	○ Severe
	Itching skin and feet	○ Mild	○ Moderate	○ Severe	History of gallbladder attacks or gallstones	○ Mild	○ Moderate	○ Severe
	Excessive falling hair	○ Mild	○ Moderate	○ Severe	Sneezing attacks	○ Mild	○ Moderate	○ Severe
	Frequent skin rashes	○ Mild	○ Moderate	○ Severe	Dreaming, nightmare type bad dreams	○ Mild	○ Moderate	○ Severe
	Bitter/metallic taste in mouth in mornings	○ Mild	○ Moderate	○ Severe	Bad breath (halitosis)	○ Mild	○ Moderate	○ Severe
	Bowel movements painful or difficult	○ Mild	○ Moderate	○ Severe	Milk products cause distress	○ Mild	○ Moderate	○ Severe
	Worrier, feels insecure	○ Mild	○ Moderate	○ Severe	Sensitive to hot weather	○ Mild	○ Moderate	○ Severe
	Feeling queasy; headache over eyes	○ Mild	○ Moderate	○ Severe	Burning or itching anus	○ Mild	○ Moderate	○ Severe
	Greasy foods upset	○ Mild	○ Moderate	○ Severe	Crave sweets	○ Mild	○ Moderate	○ Severe
	Stools light-colored	○ Mild	○ Moderate	○ Severe				

F	Loss of taste for meat	○ Mild	○ Moderate	○ Severe	Indigestion 1/2-1 hr after eating; up to 3-4 hrs	○ Mild	○ Moderate	○ Severe
	Lower bowel gas several hrs after eating	○ Mild	○ Moderate	○ Severe	Mucous colitis or “irritable bowel”	○ Mild	○ Moderate	○ Severe
	Burning stomach sensations, eating relieves	○ Mild	○ Moderate	○ Severe	Gas shortly after eating	○ Mild	○ Moderate	○ Severe
	Coated tongue	○ Mild	○ Moderate	○ Severe	Stomach “bloating” after eating	○ Mild	○ Moderate	○ Severe
	Pass large amounts of foul-smelling gas	○ Mild	○ Moderate	○ Severe				

G	1 Insomnia	○ Mild	○ Moderate	○ Severe	Inward trembling	○ Mild	○ Moderate	○ Severe
	Nervousness	○ Mild	○ Moderate	○ Severe	Heart palpitates	○ Mild	○ Moderate	○ Severe
	Can’t gain weight	○ Mild	○ Moderate	○ Severe	Increased appetite without weight gain	○ Mild	○ Moderate	○ Severe
	Intolerance to heat	○ Mild	○ Moderate	○ Severe	Pulse fast at rest	○ Mild	○ Moderate	○ Severe
	Highly emotional	○ Mild	○ Moderate	○ Severe	Eyelids and face twitch	○ Mild	○ Moderate	○ Severe
	Flush easily	○ Mild	○ Moderate	○ Severe	Irritable and restless	○ Mild	○ Moderate	○ Severe
	Night sweats	○ Mild	○ Moderate	○ Severe	Can’t work under pressure	○ Mild	○ Moderate	○ Severe
	Thin, moist skin	○ Mild	○ Moderate	○ Severe				
	2 Increase in weight	○ Mild	○ Moderate	○ Severe	Mental sluggishness	○ Mild	○ Moderate	○ Severe
	Decrease in appetite	○ Mild	○ Moderate	○ Severe	Hair coarse, falls out	○ Mild	○ Moderate	○ Severe
	Fatigue easily	○ Mild	○ Moderate	○ Severe	Headaches upon arising wear off during day	○ Mild	○ Moderate	○ Severe
	Ringing in ears	○ Mild	○ Moderate	○ Severe	Slow pulse, below 65	○ Mild	○ Moderate	○ Severe
	Sleepy during day	○ Mild	○ Moderate	○ Severe	Frequency of urination	○ Mild	○ Moderate	○ Severe
	Sensitive to cold	○ Mild	○ Moderate	○ Severe	Impaired hearing	○ Mild	○ Moderate	○ Severe
	Dry or scaly skin	○ Mild	○ Moderate	○ Severe	Reduced initiative	○ Mild	○ Moderate	○ Severe
	Constipation	○ Mild	○ Moderate	○ Severe				
	3 Failing memory	○ Mild	○ Moderate	○ Severe	Headaches, “splitting or rendering” type	○ Mild	○ Moderate	○ Severe
	Low blood pressure	○ Mild	○ Moderate	○ Severe	Decreased sugar tolerance	○ Mild	○ Moderate	○ Severe
	Increased sex drive	○ Mild	○ Moderate	○ Severe				
	4 Abnormal thirst	○ Mild	○ Moderate	○ Severe	Tendency to ulcers,colitis	○ Mild	○ Moderate	○ Severe
	Bloating of abdomen	○ Mild	○ Moderate	○ Severe	Increased sugar tolerance	○ Mild	○ Moderate	○ Severe
	Weight gain around hips or waist	○ Mild	○ Moderate	○ Severe	Women: menstrual disorders	○ Mild	○ Moderate	○ Severe
	Sex drive reduced or lacking	○ Mild	○ Moderate	○ Severe	Young girls: lack of menstrual function	○ Mild	○ Moderate	○ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

G	5	Dizziness	○ Mild	○ Moderate	○ Severe	Hair growth on face or body	○ Mild	○ Moderate	○ Severe
		Headaches	○ Mild	○ Moderate	○ Severe	Sugar in urine (not diabetes)	○ Mild	○ Moderate	○ Severe
		Hot flashes	○ Mild	○ Moderate	○ Severe	Masculine tendencies	○ Mild	○ Moderate	○ Severe
		Increased blood pressure	○ Mild	○ Moderate	○ Severe		○ Mild	○ Moderate	○ Severe
	6	Weakness, dizziness	○ Mild	○ Moderate	○ Severe	Poor circulation	○ Mild	○ Moderate	○ Severe
		Chronic fatigue	○ Mild	○ Moderate	○ Severe	Swollen ankles	○ Mild	○ Moderate	○ Severe
		Low blood pressure	○ Mild	○ Moderate	○ Severe	Crave salt	○ Mild	○ Moderate	○ Severe
		Nails, weak, ridged	○ Mild	○ Moderate	○ Severe	Brown spots or bronzing of skin	○ Mild	○ Moderate	○ Severe
		Tendency to hives	○ Mild	○ Moderate	○ Severe	Allergies - tendency to asthma	○ Mild	○ Moderate	○ Severe
		Arthritic tendencies	○ Mild	○ Moderate	○ Severe	Weakness after colds, influenza	○ Mild	○ Moderate	○ Severe
		Perspiration increase	○ Mild	○ Moderate	○ Severe	Exhaustion - muscular and nervous	○ Mild	○ Moderate	○ Severe
		Bowel disorders	○ Mild	○ Moderate	○ Severe	Respiratory disorders	○ Mild	○ Moderate	○ Severe
H		Apprehension	○ Mild	○ Moderate	○ Severe	Weakness	○ Mild	○ Moderate	○ Severe
		Irritability	○ Mild	○ Moderate	○ Severe	Fatigue	○ Mild	○ Moderate	○ Severe
		Morbid fears	○ Mild	○ Moderate	○ Severe	Skin sensitive to touch	○ Mild	○ Moderate	○ Severe
		Never seems to get well	○ Mild	○ Moderate	○ Severe	Tendency toward hives	○ Mild	○ Moderate	○ Severe
		Forgetfulness	○ Mild	○ Moderate	○ Severe	Nervousness	○ Mild	○ Moderate	○ Severe
		Indigestion	○ Mild	○ Moderate	○ Severe	Headache	○ Mild	○ Moderate	○ Severe
		Poor appetite	○ Mild	○ Moderate	○ Severe	Insomnia	○ Mild	○ Moderate	○ Severe
		Craving for sweets	○ Mild	○ Moderate	○ Severe	Anxiety	○ Mild	○ Moderate	○ Severe
		Muscular soreness	○ Mild	○ Moderate	○ Severe	Anorexia	○ Mild	○ Moderate	○ Severe
		Depression; feelings of dread	○ Mild	○ Moderate	○ Severe	Inability to concentrate; confusion	○ Mild	○ Moderate	○ Severe
		Noise sensitivity	○ Mild	○ Moderate	○ Severe	Frequent stuffy nose; sinus infections	○ Mild	○ Moderate	○ Severe
		Acoustic hallucinations	○ Mild	○ Moderate	○ Severe	Allergy to some foods	○ Mild	○ Moderate	○ Severe
		Tendency to cry without reason	○ Mild	○ Moderate	○ Severe	Loose joints	○ Mild	○ Moderate	○ Severe
		Hair is coarse and/or thinning	○ Mild	○ Moderate	○ Severe				
I		Very easily fatigued	○ Mild	○ Moderate	○ Severe	Vaginal discharge	○ Mild	○ Moderate	○ Severe
		Premenstrual tension	○ Mild	○ Moderate	○ Severe	Hysterectomy/ovaries removed	○ Mild	○ Moderate	○ Severe
		Painful menses	○ Mild	○ Moderate	○ Severe	Menopausal hot flashes	○ Mild	○ Moderate	○ Severe
		Depressed feelings before menstruation	○ Mild	○ Moderate	○ Severe	Menses scanty or missed	○ Mild	○ Moderate	○ Severe
		Menstruation excessive and prolonged	○ Mild	○ Moderate	○ Severe	Acne, worse at menses	○ Mild	○ Moderate	○ Severe
		Painful breasts	○ Mild	○ Moderate	○ Severe	Depression of long standing	○ Mild	○ Moderate	○ Severe
		Menstruate too frequently	○ Mild	○ Moderate	○ Severe				

SYMPTOM SURVEY GRADING

A Sympathetic Dominance _____

B Parasympathetic Dominance _____

C Sugar Handling _____

D Cardiovascular _____

E Liver _____

F Digestion _____

G Endocrine 1 Hyperthyroid _____ 2 Hypothyroid _____

3 Hyperpituitary _____ 4 Hypopituitary _____

5 Hyperadrenal _____ 6 Hypoadrenal _____

H B complex _____

I Female _____

APOL CHIROPRACTIC

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PEDIATRIC HISTORY FORM

REGARDING PAYMENT AND AUTHORIZATION TO TREAT A MINOR

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making a collection from the insurance company and that any amount authorized to be pain directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary, this includes radiographic examination at the doctor's discretion. It is understood and agreed the amount paid to the Doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The parent also agrees that he/she is responsible for all bills incurred at this office for their child and agrees to pay minimal charges for all services and products rendered. To waive the right of notice or exemption within the state of Alabama or any other state in regard to personal property , allows one and one half (1.5%) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Child's name _____ **Signature of parent/guardian** _____ **Date** M/D/Y _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _____ (name of individual) consent the use and disclosure of my Protected Health Information to Dr. Bob Apol for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations purposes. Healthcare operations shall include, but is not limited to, quality assessment activities, credentialing, business management, and other general operation activities. I understand that the practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "Protected Health Information," means any information including my demographic information, created or received by the practice, that relates to my past, present, or future physical or mental health or condition, the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand that I have a right to review the practice's Notice of Privacy Practices prior to signing this document. The Notices of Privacy Practice describes my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the physician or practice has acted in reliance on this consent.

Child's name _____ **Signature of parent/guardian** _____ **Date** M/D/Y _____

Name of parent/guardian _____ **Description of representative's authority** _____