STALHEIM CHIROPRACTIC S.C.

NEW PATIENT HISTORY – PEDIATRIC
DATE ____________________

Child's Name ______________________ Age ________ Date of Birth ______________
Address: ______________________ Apt.# ______________
City: ______________________ State: __________ ZIP: ______________
Sex: Male Female Weight: __________ Height: __________
Mother's Name: ______________________ Father's Name ______________________
Home Phone: __________ Mother's Work Phone: __________ Father's Work Phone: __________
Mother's Occupation: ______________________ Employer: ______________________
Father's Occupation: ______________________ Employer: ______________________
Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other ______________
Parent's Email Address ______________________
Emergency Contact: ______________ Relation __________ Phone ______________
How did you hear of our office? ______________________

Current Complaint:

Purpose for contacting this office today / Primary Complaint: ______________________

____

Physical Location of Complaint: ______________________
When did this condition start? ______________________
How did this condition start? ______________________
Prior history of this condition? Yes ☐ No ☐ When? ______________________
Other doctors seen for this condition? Yes ☐ No ☐ When? __________ Doctor's Name __________
Treatment Received: ______________________
Name of child's pediatrician (if any)? ______________________
Previous Chiropractor? ______________________
Date of Last Visit __________ Reason: ______________________
List any medications and supplements that your child is currently taking: ______________________

____

List any falls, injuries, accidents, emergency care, car accidents or other trauma your child has had ______________

____

Is/has your child been involved in any sports? Yes ☐ No ☐ List ______________________
Has your child had any prior surgery? ______________________

____

Has your child been immunized? Yes ☐ No ☐

Family History:

Please list the names, ages, and any health problems of the child's siblings: ______________________

____

Is there a family history of any similar conditions? Yes ☐ No ☐ If yes, who in family? ______________

Prenatal History :

Injury to mother during pregnancy? Yes ☐ No ☐ List ___________________________

Complications during pregnancy? Yes ☐ No ☐ List___________________________

Medications during pregnancy? Yes ☐ No ☐ List___________________________

Cigarette / Alcohol use during pregnancy? Yes ☐ No ☐ List ___________________________

Location of Birth: Hospital ☐ Birthing Center ☐ Home ☐

Birth Intervention: Forceps ☐ Vacuum Extraction ☐ Caesarian Section ☐ (Emergency ☐ Planned ☐)

Complications during delivery: Yes ☐ No ☐ List___________________________

Genetic disorders or disabilities: Yes ☐ No ☐ List___________________________

Child's Health History (please check any that apply)

NOW	PAST		NOW	PAST	
____	____	Acne	____	____	Hearing loss
____	____	Allergies	____	____	Heart murmur
____	____	Anemia	____	____	High fever
____	____	Asthma	____	____	Hives
____	____	Bed wetting	____	____	Hyperactivity
____	____	Birth defects	____	____	Insomnia
____	____	Chicken pox	____	____	Joint pains
____	____	Chronic rashes	____	____	Learning disorder
____	____	Colic	____	____	Measles
____	____	Constipation	____	____	Mononucleosis
____	____	Cough/Wheeze	____	____	Moodiness
____	____	Croup	____	____	Mumps
____	____	Depression	____	____	Nosebleeds
____	____	Diarrhea	____	____	Pneumonia
____	____	Dizzy spells	____	____	Rheumatic fever
____	____	Earaches	____	____	Rubella
____	____	Ear infections	____	____	Scarlet fever
____	____	Eczema	____	____	Stomachaches
____	____	Epilepsy/seizures	____	____	Strep throat
____	____	Fatigue	____	____	Stuffy nose
____	____	Flat feet	____	____	Thrush
____	____	Frequent colds	____	____	Tonsillitis
____	____	Frequent headaches	____	____	Urinary tract infections
____	____	Frequent urination	____	____	Vomiting spells
____	____	Hair loss	____	____	Whooping cough
____	____	Headaches	____	____	Other: ______________

Allergies:

Is your child allergic or hypersensitive to any medications, foods, or environmental or chemical agents? ______________

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered my child are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my child's care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my child's condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative 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 or guardian also agrees that he/she is responsible for all bills incurred at this office and payment is ultimately the responsibility of the parent or guardian of this minor patient regardless of insurance.

Consent to treat a Minor by: ______________________________ **Relation:** ______________

Parent or Guardian's Signature Authorizing Care: ______________________________ **Date:** __________

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Parent or Guardian's Signature: ______________________________ **Date:** ______________

STALHEIM CHIROPRACTIC INFORMED CONSENT DOCUMENT (for minor child):

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear. As the parent or guardian of the patient, it is your responsibility to be informed of, understand and consent to procedures performed in our office.

The nature of the chiropractic adjustment:
The primary treatment used in this office as Doctors of Chiropractic is the chiropractic adjustment. We will be using that procedure to treat your child. We may use my hands or a mechanical instrument upon your child's body in such a way to move its joints. That may cause and audible "pop" or "click" noise much as you have experienced when you have had your knuckle or other joint "crack". He or she may feel a sense of movement when the adjustment occurs.

Analysis / Examination / Treatment:
As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ chiropractic adjustments	___ palpation	___ vital signs
___ range of motion testing	___ surface EMG testing	___ spinal thermography
___ muscle strength testing	___ orthopedic testing	___ neurological examination
___ posture analysis	___ radiographic studies	___ soft-tissue therapy

___ other ____

If there are any of the listed procedures that you do not consent to having performed, please cross-out the procedure name and initial on the line next to the procedure.

The material risks inherent in chiropractic adjustments.
As with any healthcare procedure, there are certain potential complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serous complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if your child has a condition that would otherwise not come to my attention, it is your responsibility to inform us.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and is estimated to occur between one in one million and one in five million cervical spine adjustments. These other complications are also generally described as rare.

The availability of other treatment options:
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain medication
- Hospitalization
- Surgery

If you choose to use one of the above noted options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed this with my child's doctor and have had questions answered. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to have my child undergo the treatment recommended.

Patient Name (minor) Printed ____

Parent/Guardian Name Printed ____

Parent/Guardian Signature ______________________________ **Date** ____________________