ROCHESTER FAMILY CHIROPRACTIC

Chiropractic…for all ages and health stages.

PEDIATRIC 10-17 YRS HEALTH HISTORY

WELCOME.

Chiropractic is the health care profession whose focus on proper alignment of the spine, can help restore nervous system function and allow true health to be expressed.

Patient Name: _____ Nickname:_____
Name of Parents / Guardians: _____
Mailing Address: _____
Birth Date: _____/ _____/_____ Age:_____ Sex: _____ Weight: _____ Height: _____
Home Phone: _____ 2nd Phone/cell: _____
Parental email address (for office communications only): _____
How did you hear of us?_____ If referred, whom may we thank? _____

PURPOSE FOR CONTACTING US?

( )Spinal well-care ( )Other: _____
Date of onset:_____/ _____/_____ Severity rating: 0/none - 1-2-3-4-5-6-7- 8-9-10/extreme
Describe all symptoms::_____
Are symptoms ( )constant ( )comes & goes ( )local ( )radiating/moves ( )getting worse?
Frequency of discomfort?_____
What makes it better? ( )time of day, ( )position, ( )other: _____
What makes it worse? ( )time of day, ( )position, ( )other: _____
Have any of the following been done? ( )Prescription/OTC Medication:_____
( )Surgery ( )Physical Therapy ( )Other: _____
Any difficulty with ( )sleep ( )recreation ( )daily routine ( )Other:_____
Any other changes in bodily function? _____

Previous chiropractic care? ( )No ( )Yes (name/date/reason):_____
Other doctor(s) seen for this condition? (names/dates) _____
Any other health concerns?_____

CHILD'S HEALTH PROFILE.

Please mark "0" for a past condition, "X" for present condition

_____Ear Infections	_____ADHD	_____ Colic	_____Back Pain
_____Scoliosis	_____Chronic Colds	_____Asthma/Allergies	_____Neck Pain
_____Seizures	_____Headaches	_____Recurring Fevers	_____Muscle/joint Pain
_____Bed Wetting	_____Digestive	_____Growing Pain	_____Poor posture

Other:_____
Current Pediatrician: _____Phone:_____
Date of last visit: _____/_____/_____ Reason:_____
Number of antibiotics doses your child has taken over his/her lifetime:_____
Past and current medications:_____
Nutritional supplements/vitamins:_____

Please list any major illnesses/surgeries your child has had:_____
Has your child ever been involved in a car accident? _____
Has your child ever been seen on an emergency basis?_____
Has your child ever had any other trauma? _____
Is your child involved in high-impact or contact sports?_____

VACCINATION HISTORY:

( )Chosen to decline ( )On schedule ( )Undecided Any adverse reactions?_____

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PEDIATRIC 10-17 YRS HEALTH HISTORY

FAMILY HEALTH HISTORY CHECK HERE IF CHILD IS ADOPTED:_____.

Indicate using the letters if any of the biological relatives of the patient had the following. Mother(M) Father(F) Siblings(S) Paternal grandmother (PGM) Paternal grandfather(PGF) Maternal grandmother(MGM) Maternal grandfather(MGF)

____Asthma	____Hypertension	____Eczema	____Kidney Disease
____Diabetes	____Ulcers	____Heart Disease	____Stroke
____Scoliosis	____Cancer	____Mental Illness	____Other
____Allergies	____Liver disease	____Hypoglycemia	

PRENATAL HISTORY:

Premature delivery? ( )NO ( )YES Breech Presentation? NO / YES

Birth intervention? ( )Forceps ( )Vacuum Extraction ( )Pulling

Cesarean section? Emergency:____ Planned:____

Complications during delivery? NO / YES List:_____

Genetic Disorders or Disabilities: NO / YES List:_____

NUTRITIONAL HISTORY:

Food allergies or intolerances: NO / YES List:_____

DEVELOPMENTAL HISTORY:

Is height/weight growth delayed? NO / YES Has puberty begun? NO / YES age:_____

Menstruation: NO / YES Age: _____ First day of last menstrual cycle: _____

CHILDHOOD DISEASES:

Place an X if your child has had any of the following childhood diseases.

Chicken pox_____ Mumps_____ Rubella _____ Measles _____ Whooping Cough_____

LIFESTYLE QUESTIONS:

How often does your child consume soda? rarely____1-2x/day____2-3x/day____more____

Does your child eat balanced, healthy meals? rarely____1-2x/day____2-3x/day____more____

Does your child eat fast foods/prepared food? rarely____1-2x/day____2-3x/day____more____

Is your child's backpack more than 10% of their body weight? NO / YES List approx wt_____

How many hours a day does your child watch TV/computer/video games?_____

How many hours a day does your child play/engage in sports?_____

Is your child comfortable in social settings? NO / YES

Average hours of sleep your child gets per night?_____

WE ARE HERE TO SERVE YOU AND YOUR FAMILY.
WE ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR FAMILY'S RESULTS.

AUTHORIZATION AND CARE OF MINOR

I hereby authorize Dr. Laura Nicholson to administer chiropractic care to my Son/Daughter.

Child's Name:_____

Parent/Guardian signature:_____Date:_____

CONSENT TO CHIROPRACTIC CARE

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Laura Nicholson, D.C. and/or any other chiropractic personnel who may be involved in the course of my treatment. Procedures may include the following: patient history, patient exam with orthopedic, neurological and chiropractic assessment, diagnostic x-rays, report of findings, chiropractic adjustments, heat and cold therapy, therapeutic massage and reassessment exams. I understand that Dr. Nicholson and/or personnel will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that with all health care delivery systems, including medicine, the practice of chiropractic may have potential complications. Possible risks may include post-treatment soreness, disc injury aggravation, joint, ligament, tendon or soft tissue injury and osseous tissue injury. As for a risk of stroke, according to the journal, *Spine* 2008; 33 (4S):S176-S183, patients are no more likely to suffer a stroke following a visit to a chiropractor than they would after stepping into their family doctor's office. The potential incidence is so rare that it is considered statistically insignificant. Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms. I acknowledge, fully understand and agree to inform my medical physician of my present health condition in order to exclude any possible underlying pathology. Chiropractic is not a disease oriented treatment method, rather a focus on the body's ability to reach its maximum potential for healing.

I understand that chiropractic care involves the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me. I wish to rely on Dr. Nicholson to exercise judgment during the course of the procedure which she feels at the time, based upon the facts then known, is in my best interests. I have had an opportunity to discuss to my satisfaction with Dr. Nicholson, or other clinic personnel the nature and purpose of chiropractic adjustments and therapy procedures. By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents.

Guardian/Parent Printed Name **Signature** **Date**

VERIFICATION OF NON-PREGNANCY (FEMALES ONLY)

I verify to the best of my knowledge that my child is NOT pregnant at this time and have given permission to perform diagnostic radiographs.

Guardian/Parent Printed Name **Signature** **Date**

AUTHORIZATION OF PAYMENT

I authorize and request my insurance carrier to pay directly to Rochester Family Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Guardian/Parent Printed Name **Signature** **Date**

NOTICE OF PRIVACY PRACTICES

I acknowledge that Rochester Family Chiropractic "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Rochester Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of use and disclosures of my protected health information that will occur in my care, payment of my bills and/or in the performance of health care operations of Rochester Family Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practice for Rochester Family Chiropractic is available at the main administrative desk of this practice. Rochester Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy.

Guardian/Parent Printed Name **Signature** **Date**

Office Personnel **Signature** **Date**