ROCHESTER FAMILY CHIROPRACTIC

Chiropractic is the health care profession that focuses on the proper alignment of the spine, eliminating nervous system interference and allowing true health to be expressed. Welcome to Rochester Family Chiropractic.

HISTORY (0-9 years) PEDIATRIC

Patient Name: _____ _____
Name of Parents / Guardians: _____
Address: _____ City: _____
State: _____Zip: _____ Birth Date: _____/ _____/_____
Sex: _____ Weight: _____ Height: _____
Home Phone: _____Work Phone: _____
Parental email address: _____
How did you hear of us?_____
If referred, whom may we thank? _____

PURPOSE FOR CONTACTING US?

( )Spinal well-care/prevention ( )Other (please explain): _____
Other doctors seen for this condition? ( )NO ( )YES, please list Doctor's names and treatments:

_____
_____
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:_____

Name of Obstetrician /Widwife: _____Phone:_____
Name of Pediatrician: _____Phone:_____
Date of last visit: ____/____/____Reason: _____
Are you satisfied with the care your child has received there? NO / YES
Number of antibiotics doses your child has taken over his/her lifetime: _____
Past and current medications:_____
Any 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?_____

According to National Safety Council, approximately 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.)

Has your child fallen from a height of over three feet? ( )NO ( )YES, at what age: _____
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? _____

FAMILY HEALTH HISTORY

CHECK HERE IF CHILD IS ADOPTED:_____. Indicate using the letters if any of the blood 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:

Complications during pregnancy? NO / YES List _____
Medications during pregnancy? NO / YES List _____
Cigarette/ Alcohol/ Drug use during pregnancy? NO / YES List _____
Location of Birth: ( )Birthing Center ( )Home ( )Hospital

BIRTH HISTORY:

Birth Weight: _____ Birth Length: _____APGAR Scores: _____, _____
Premature delivery? ( )NO ( )YES, list at what week:_____
Breech Presentation? ( )NO ( )YES; Breech____, Transverse/Side____, Face/Brow____
Birth intervention? ( )Forceps ( ) Vacuum Extraction ( ) Pulling
Cesarean section? ( )Emergency ( ) Planned
Complications during delivery? ( )NO ( )YES, list:_____
Medications during delivery? ( )NO ( )YES List:_____
Genetic Disorders or Disabilities: ( )NO ( )YES List:_____

FEEDING HISTORY:

Breast fed: ( )NO ( )YES, list for how long: _____
Formula fed : ( )NO ( )YES, list for how long:_____
Difficulty breastfeeding?_____ Introduced to solids at: _____ months
Food allergies or intolerances: _____

DEVELOPMENTAL HISTORY:

During the following times your child's spine is vulnerable to stress and greatly benefits from routine spinal checks for the prevention and detection of vertebral subluxation (spinal nerve interference). Place an X if your child has/had difficulty during the following stages.

_____ Respond to sound	_____ Crawl	_____ Walk Alone
_____ Hold head up	_____ Sit alone	_____ Talking
_____ Roll over	_____ Stand alone	

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 juice? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
How often does your child consume milk? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
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 consume artificial sweeteners ( )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 exposed to smoke? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
Is your child's backpack more than 10% of their body weight? ( )NO ( )YES, aprox. 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 uncomfortable in social settings? ( )NO ( )YES_____
Average hours of sleep your child gets per night?_____ Naps? ( )NO ( )YES

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's signature:_____Date:_____

Parent's printed name:_____

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 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.

_____

Printed Parent/Guardian 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 child's behalf.

_____

Printed Parent/Guardian 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.

_____

Printed Parent/Guardian Name Signature Date

_____

Office Personnel/Witness