ADIO CHIROPRACTIC

Today's Date: _____ **PEDIATRIC HISTORY FORM** HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____/_____/_____ Age: _____

❑ Male ❑ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____City: _____ State: ____ Zip: _____

Mother's Name: _____ Birthdate: _____/_____/_____

Mother's Phone: Home _____ Work _____ Cell_____

Mother's Email: _____

Father's Name: _____ Birthdate: _____/_____/_____

Father's Phone: Home _____ Work _____ Cell_____

Father's Email: _____

Pediatrician/Family MD: _____ City/State: _____

Clinic Name: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

Other Health Care Professionals
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Message Therapist, etc)

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of Last Visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of Last Visit: _____

May we communicate with your family doctor regarding your child's care if necessary? ❑ Yes ❑ No

Who is responsible for this bill? _____

❑ Father's Social Security #: _____-_____-_____ ❑ Mother's Social Security #: _____-_____-_____

❑ Father's Driver's License #: _____ ❑ Mother's Driver's License #: _____

❑ Other *(please explain)*: _____

How did you hear about us?

_____

Siblings and ages:

_____

Has your child received previous chiropractic care? ❑ Yes ❑ No

Emergency Contact

Name: _____Relationship to Child: _____

Phone Number: _____ Alternative Phone Number: _____

PATIENT'S NAME:_____ HR:_____ DATE:_____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ❑ Wellness Check-up ❑ Injury or Accident ❑ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ❑ Unknown ❑ Gradual ❑ Sudden
2. Has this problem occurred before? ❑ No ❑ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ❑ No ❑ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ❑ No ❑ Yes **If yes**, whom? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ❑ Rapidly Improving ❑ Improving Slowly ❑ About the Same ❑ Gradually Worsening ❑ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ❑ No ❑ Yes **If yes,** please explain:

_____

_____

10. Has your child ever sustained an injury in an auto accident? ❑ No ❑ Yes **If yes,** please explain:

_____ Initial

What signals has your child's body been communicating?

Current	Previous		Current	Previous		Current	Previous	
❑	❑	Asthma	❑	❑	Frequent Diarrhea	❑	❑	Slow Weight Gain
❑	❑	Respiratory Tract Infections	❑	❑	Constipation	❑	❑	Slow or Absent Reflexes
❑	❑	Sinus Problems	❑	❑	Flatulence	❑	❑	Asymmetrical Crawling or Gait
❑	❑	Ear Infections	❑	❑	Headaches / Migraines	❑	❑	Weight Challenges
❑	❑	Tonsillitis	❑	❑	Neck Pain	❑	❑	Bed Wetting
❑	❑	Strep Throat	❑	❑	Torticollis / Head Tilt	❑	❑	Sleep Problems
❑	❑	Frequent Colds / Croup	❑	❑	Trouble Feeding on One Side	❑	❑	Night Terrors
❑	❑	Recurrent Fevers	❑	❑	Back Pain	❑	❑	Tip Toe Walking
❑	❑	Eczema	❑	❑	Growing Pains	❑	❑	Sensory Processing Issues
❑	❑	Rashes	❑	❑	Scoliosis	❑	❑	Seizures
❑	❑	Allergies	❑	❑	Red, Swollen, Painful Joint	❑	❑	Tremors / Shaking
❑	❑	Food Sensitivities	❑	❑	Colic	❑	❑	ADD / ADHD
❑	❑	Digestive Problems	❑	❑	Frequent Crying Spells	❑	❑	Autism / PPD
❑	❑	Other: _____						

❑ None of above, I would like my child's nervous system assessed to achieve optimal health & functioning. (skip "Health Concern section)

PATIENT'S NAME:_____ HR:_____ DATE:_____

HISTORY OF COMPLAINT

	Health Concerns: List according to severity	If Pain, Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If your child has had the condition before, when?	Any medication for this condition?	Any other treatment received for this?
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____

Birth Experience (Please complete to best of your knowledge)

Location of Birth: ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other: _____

Birth Attendants: ❑ Doula ❑ Midwife ❑ GP ❑ OB ❑ Other: _____

Medications during labor/delivery (including IV antibiotics): ❑ No ❑ Yes: _____

Was Pitocin used to induce / speed up labor? ❑ No ❑ Yes

Was you child at any time during pregnancy in a constrained position? ❑ No ❑ Yes ❑ Unsure

If yes, please describe: ❑ Breech ❑ Transverse ❑ Face / Brow presentation

Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ❑ Head ❑ Face ❑ Breech

Were any of the following intervention used? ❑ Forceps ❑ Vacuum Extraction ❑ Other

If yes, please specify: _____

How long was labor from the first regular contractions to birth? _____ hours.

How long was the second stage (the pushing phase) of the labor? _____ hours.

Was the baby born with any purple markings / bruising on their face or head? ❑ No ❑ Yes

Any concerns about misshapen head at birth? ❑ No ❑ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

If known, APGAR scores at: 1 minute: _____/10 5 minutes: _____/10

Was the baby ever admitted to the NICU? ❑ No ❑ Yes

If yes, for how long and why? _____

Was any medication given to the child at birth? ❑ No ❑ Yes ❑ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ❑ No ❑ Yes ❑ Months: _____

Did your child show any sensitivities to formula? (reflux, eczema, arching back) ❑ No ❑ Yes

What age did you introduce solid foods to your child? _____ Months

Did your child spend a lot of time in any baby devices?

❑ No ❑ Yes which types? (circle) BOUNCY SEATS SWINGS BUMBOS CAR SEATS JUMPERS OTHER

PATIENT'S NAME:_____ HR:_____ DATE:_____

Physical Traumas

Has your child ever fallen from any high places? ❑ No ❑ Yes

Has your child ever been involved in a motor vehicle accident? ❑ No ❑ Yes

Has your child broken any bones? ❑ No ❑ Yes

Has your child had any previous hospitalizations? ❑ No ❑ Yes

Has your child had any previous surgeries? ❑ No ❑ Yes

Does your child use a tablet, computer, or video game? ❑ Never ❑Rarely ❑Daily ❑Several hrs./day

Does your child watch TV? ❑ Never ❑ Rarely ❑Daily ❑ Several hrs./day Does your child

Does your child exercise? ❑ Never ❑ Rarely ❑Daily ❑ Several hrs./day Does your child

Does your child play contact sports? ❑ No ❑ Daily ❑Weekly ❑Seasonally

Does your child sleep on there ... ❑ Back ❑Belly ❑Sides (both, right, left)

Does your child carry a back pack? ❑ No ❑ Yes

Does it weigh less than 15% of their body weight? ❑ No ❑ Yes

Do they wear their back pack on 2 shoulders? ❑ No ❑ Yes

Does your child's shoes show excessive or uneven wearing out? ❑ No ❑ Yes

Does your child wear custom orthotics? ❑ No ❑ Yes

If yes, for what purpose?_____

Do you feel your child developmentally appropriate for their age?

Intellectually: ❑ Yes ❑ No _____

Emotionally: ❑ Yes ❑ No _____

Physically: ❑ Yes ❑ No _____

I understand that I am directly and fully responsible to ADIO Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ ____ - ____ - ____

Parent or Legal Guardian's Signature **Date Completed**

_____ ____ - ____ - ____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME:_____ HR:_____ DATE: _____

Family Health History

This form is to assist the doctor by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

ADIO CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at ADIO Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

Name of patient who is a minor/child _____

I authorize Dr. Zachary Cadman and all ADIO Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify ADIO Chiropractic.

____/____/____ _____

Date Guardian Signature and Relationship to Minor/Child

_____ ____/____/____ *Witness Initials*

Witness Signature (office staff) Date