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BALANCE FAMILY CHIROPRACTIC PEDIATRIC HEALTH HISTORY FORM

Childs Name: _____ Age: _____ Birth Date: _____ Sex: M or F
Name of Parent(s)/Guardian: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Phone Number: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
How did you hear about our office?
_____

Reason for Visit: Wellness Check-Up _____ Health Concern _____
Please explain if health concern:
_____
Have you seen other doctors for this condition? Yes or No Who? _____
Type of Treatment: _____ Results: _____
Other Health Problems? _____
_____

Check any of the following that your *CHILD* has suffered from during the past 6 months:

_____ Ear Infections _____ Asthma
_____ Headaches
_____ Car Accident _____ Digestive Problems

_____ Other _____
Has any other family member suffered from these symptoms? _____Yes _____ No

Previous Chiropractor? _____
Date of Last Visit: _____ Reason: _____
Name of Pediatrician: _____
Date of Last Visit: _____ Reason: _____

_____ Scoliosis	_____ Bed Wetting	_____ Fatigue	_____ Neck/Back Pain
_____ Cold/Sinus	_____ Seizures	_____ Colic	_____ ADD/ADHD
_____ Allergies	_____ Recurrent Fevers	_____ Temper Tantrums	

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____
List of Antibiotics: _____
Vaccination History: _____
Any adverse reactions to vaccinations? _____

BALANCE
FAMILY CHIROPRACTIC

Prenatal History:

Name of Obstetrician/Midwife: _____
Complications during pregnancy? _____ No _____ Yes – List: _____
Ultrasounds during pregnancy? _____ No _____ Yes – Number: _____
Medications during pregnancy? _____ No _____ Yes – List: _____
Cigarette/Alcohol Use during pregnancy: _____ No _____ Yes

Location of Birth: _____ Hospital _____ Home _____ Birthing Center
Birth Intervention: _____ Forceps _____ Vacuum Extraction
____ Caesarian Section – Emergency or Planned? _____
Complication during delivery: _____ No _____ Yes – List: _____
Genetic Disorder or Disabilities: _____ No _____ Yes – List: _____
Birth Weight: _____ pounds _____ ounces

Birth Length _____ inches APGAR Scores _____

Feeding History:

Breast Fed: _____ No _____ Yes – How Long: _____
Formula Fed: _____ No _____ Yes – How Long: _____ Type: _____ Introduced solids at: _____ months Cow's Milk at: _____ months
Food/Juice Allergies or Intolerances? _____ No _____ Yes
List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Respond to Visual Stimuli _____ Hold Head Up
_____ Cross Crawl _____ Sit Up _____ Stand Alone _____ Walk Alone

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

Is/was your child involved in any high impact or contact sports? _____ No _____ Yes
(i.e. football, soccer, gymnastics, baseball, basketball, cheerleading, martial arts, etc...)
Sport(s): _____

Has your child ever been involved in a car accident? _____ No _____ Yes
List: _____

Has your child ever been seen on an emergency basis? _____ No _____ Yes
List: _____

Other Traumas not listed above? _____ No _____ Yes – List: _____
Prior Surgery? _____ No _____ Yes – List: _____
Menarche? _____ No _____ Yes – Age: _____

Childhood Diseases:

Chicken Pox: N/Y – Age: _____ Rubella: N/Y – Age: _____
Whooping Cough: N/Y – Age: _____ Mumps: N/Y – Age: _____
Rubeola/Measles: N/Y – Age: _____ Other: N/Y – Age: _____

Upon completion of your child's first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you and your child in reaching all of your health goals.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me or my child are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

However, the patient or responsible party remains liable for any amount not paid by insurance, if any, within 30 days of our request for payment. In the event that payment is not timely made, and we must place the account for collections, you agree to pay all of our reasonable costs and expenses, including attorney fees, related to the collection of any sums due. A finance charge of 1.5% per month (Annual Percentage Rate 18.0%) will be added to the account, but the finance charge will not begin to accrue until thirty days after our request for payment.

I hereby authorize the doctor to treat my child's condition, as she deems appropriate. It is understood and agreed the amount paid for the doctor, for x-rays, is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient's parent or guardian also agrees that he/she is responsible for payment of all bills incurred at this office.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care for my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Date: _____

PATIENT NAME_____

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.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	range of motion testing
muscle strength testing	postural analysis
palpation	vital signs
orthopedic testing	basic neurological
trigger point	radiographic studies

Other (please explain)

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious 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 you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

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 incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature 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-killers
- Hospitalization
- Surgery

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

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility; which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ackerman and Dr. Hybl and have had my questions answered to my satisfaction. 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 undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctor's Name

_____ _____
Signature Signature

_____
Signature of Parent or Guardian (if a minor)

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