NEW PEDIATRIC PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying for your child to be a patient in our clinic. Our doctors are trained with techniques specific to adjusting the pediatric spine. Children often don't require as much care as an adult, however, we will evaluate and give the best recommendations for your child. Please know if we do accept your child as a patient, we will then make a specific plan based upon our understanding that their health is your

TOP PRIORITY.

PATIENT NAME ____

DATE COMPLETED ____

Child's Name: ______________________ Birth Date:____ /___ / ______ Height: ______ Gender: ☐ M ☐ F
Parent(s)/Guardians' Names: ______________________
Home Address: ______________________
Home Phone: ____________ Parent's Cell Phone: ____________ Parent's Work Phone ____________
Parent's Email: ______________________
How did you hear about us? ______________________
Siblings and ages: ______________________
Previous Chiropractic Care? ☐ No ☐ Yes

Emergency Contact:
Name: ______________________ Relationship to child: ______________________
Phone Number: ______________________ Alternate phone number: ______________________

Family Doctor
Name: ______________________ Proffesional Designation: ______________________
Clinic Name: ______________________ Date and reason of last visit: ______________________
May we communicate with your family doctor regarding your child's care if necessary? ☐ No ☐ Yes

Other Healthcare Professionals
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)
Name: ______________________ Proffesional Designation: ______________________
Clinic Name: ______________________ Date and reason of last visit: ______________________

Name: ______________________ Proffesional Designation: ______________________
Clinic Name: ______________________ Date and reason of last visit: ______________________

Why have you decided to have your child evaluated by a Chiropractor?
☐ He/ She is continuing ongoing care from another chiropractor.
☐ I recently had my spine checked and understand the value in getting my child checked.
☐ I have concerns about his/her health and I'm looking for answers.
☐ He/ She has a specific condition and I've learned that chiropractic might be able to help.
☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *vertebrae*. Many of the common health challenges that adults experience have their origins during the *developmental years*, some starting at birth. Layers of damage to the spine and nervous system occur as a result of various *traumas, toxins, and emotional stress.* The result may be misalignment to the spinal column and damage to the *nervous system* - a condition called *Vertebral Subluxation*. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's *ability to heal*.

CERVICAL SPINE (NECK)

NOW	PAST	
☐	☐	Sinus Problems
☐	☐	Strep Throat
☐	☐	Recurrent Fevers
☐	☐	Neck Pain
☐	☐	Headaches/Migraines
☐	☐	Ear Infections
☐	☐	Frequent Colds/Croup
☐	☐	Rashes
☐	☐	Torticollis/Head tilt
☐	☐	Slow or Absent Reflexes
☐	☐	Tonsillitis
☐	☐	Eczema
☐	☐	Allergies
☐	☐	Trouble feeding on one side

THORACIC SPINE(UPPER & MID BACK)

NOW	PAST	
☐	☐	Asthma/Wheezing
☐	☐	Failure to thrive/Slow Weight Gain
☐	☐	Upper Back Pain
☐	☐	Colic
☐	☐	Respiratory Tract Infections
☐	☐	Digestive Problems
☐	☐	Sinus Problems
☐	☐	Mid Back Pain
☐	☐	Frequent Crying Spells
☐	☐	Scoliosis
☐	☐	Food Sensitivities

LUMBAR SPINE (LOWER BACK)

NOW	PAST	
☐	☐	Frequent Diarrhea
☐	☐	Weight Challenges
☐	☐	Constipation
☐	☐	Growing Pains
☐	☐	Bed Wetting
☐	☐	Seizures
☐	☐	Low Back Pain
☐	☐	Flatulence (Excessive gas)
☐	☐	Tip Toe Walking
☐	☐	Sensory Processing Issues
☐	☐	Asthma/Wheezing
☐	☐	Menstrual Irregularities
☐	☐	Asymmetrical crawling

OTHER

NOW	PAST	
☐	☐	Red Swollen, Painful Joint
☐	☐	Tremors/Shaking
☐	☐	ADD/ADHD
☐	☐	Night Terrors
☐	☐	Autism PPD
☐	☐	Sleep Problems

Do you have a specific concern that brings you in?

☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.

☐ Yes: ____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? ☐ No ☐ Yes For how long ? ____________________

Is it getting better, worse, or staying the same? ______________ Suddenly or gradually? ______________

Have you seen other health professionals regarding this complaint? ☐ No ☐ Yes If yes, whom? __________

What treatment did they use? ______________________________________

Has your child taken any medication for this complaint? ☐ No ☐ Yes: ____________________

Has your child ever experienced this complaint before? ☐ No ☐ Yes: ____________________

Has your child received any treatment at this time? ☐ No ☐ Yes: ____________________

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: ____________________

Has your child had any blood work done for the current complaint? ☐ No ☐ Yes: ____________________

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐No ☐ Yes (brief description): ______________________________

Ultrasounds during pregnancy: ☐No ☐ Yes (brief description):______________________________

Medications during pregnancy: ☐No ☐ Yes (brief description):______________________________

If so which ones and how often? (include OTC): ______________________________

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐ No ☐ Yes (brief description): ______________________________

Birth Experience

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

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your 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 interventions used? ☐ Forceps ☐ Vacuum ☐ Extraction ☐Other

Were there any complications during delivery? ☐No ☐Yes

If yes, please specify: ______________________________

How long was the labor from the first regular contractions to the 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

Postnatal & Infant History

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

If known, APGAR score at: 1 minute: _______/10 5 minutes:_______/10

Was the baby ever administered 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: ________

Was your child breastfed + formula fed? ☐ 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 you introduce cereal or grains within your child's first year? ☐ No ☐Yes

Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc)?

☐ No ☐Yes Which ones? ______________________________

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 been seen on an emergency basis? ☐ 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 exercise? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

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

Does your child sleep on their. . . ☐ Back ☐ Belly ☐ Sides (both, right, left)

Does your child carry a backpack? ☐ No ☐ Yes

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

Do they wear their backpack on 2 shoulders? ☐ No ☐ Yes

Does your child show excessive or uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear custom orthotics?

☐ No ☐ Yes, For what purpose? ____________________

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed schedule ☐ Yes, on schedule

Reason for vaccination: ☐ Personal research ☐ Didn't know I had a choice ☐ It was recommended

Reaction(s) to vaccination: ☐ None ☐ Fever ☐ Diarrhea ☐ Rash ☐ Welt at injection site

☐ Fatigue ☐ Seizures ☐ Prolonged cry ☐ Developmental regression

☐ Other: ____________________

Does your child receive annual flu shots? ☐ No ☐ Yes(personal research) ☐ Yes (MD recommended)

Has your child been exposed to antibiotics? ☐ No ☐ Yes

If yes, how many doses in the past 6 months? _____ Reasons: ____________________

Has your child been exposed to medications, including OTC? ☐ No ☐ Yes

If yes, which ones? ____________________

If yes, how many doses in the past 6 months? _____ Reason: ____________________

How many glasses of water/day does your child have? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of cow's milk , juice, and soda/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Does your child eat gluten? ☐ No ☐ Yes ☐ Trying to eliminate

Does your child eat dairy? ☐ No ☐ Yes ☐ Trying to eliminate

Any food/drink allergies or sensitivities? ☐ No ☐ Yes ____________________

Is your child exposed to secondhand smoke? ☐ No ☐ Yes ____________________

Does your child take a probiotic daily? ☐ No ☐ Yes ________ CFU'S/day

Does your child take a vitamin D3 daily? ☐ No ☐ Yes ________ IU's/day

Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes ________ mg/day

Other supplements or homeopathics? ______________________________

Goals & Consent

Do you feel like your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐No ______________________________

Emotionally: ☐ Yes ☐No ______________________________

Physically: ☐ Yes ☐No ______________________________

What is your primary goal for your child at our clinic?

____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation.

AUTHORIZATION TO CARE FOR A MINOR

I hereby authorize the Doctor(s) in this Chiropractic office, and whomever they may have designate as their assistants to administer chiropractic care, to work with my child (name)______________________________ through the use of chiropractic adjustments and other procedures, as the Doctor(s) deem(s) appropriate.

I clearly understand and agree that all services are charged directly to me and I am personally responsible for payment to Pure Life Chiropractic. I agree I am responsible for all bills incurred in this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions not for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and the policyholder. I understand that the Doctor's office will prepare any necessary reports or forms to assist me in collecting from the insurance company.

In the event this minor is being seen as a part of an automobile accident/ injury, I authorize the amount due for Chiropractic care to be paid directly to the Doctor's office. This will be credited to my account upon receipt. If the insurance payment comes directly to me, I will then pay the Doctor's office immediately. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the Provider for services rendered to my minor.

____
Patient's Name (Print)

____
Parent or Legal Guardian (Print)

____
Parent/Guardian Signature Authorizing Care

____
Office Manager's Signature

____
Date

____
Date

Photo/Video Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Pure Life Chiropractic, its affiliates or agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproductions of me and/or record my voice.

(b) Permission to use my first name; and last initial.

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me,, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (Including the internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given perpetuity, and does not require prior approval by me.

Name: ____

Signature: ____

Address:____

____

Date:____________________

This below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent

Or Legal Guardian: ______________________________ Print Name: ______________________________

____________________ ____

Date Witness Signature