CALHOUN CHIROPRACTIC
Wellness Center

NEW PRACTICE MEMBER PAPERWORK

PEDIATRIC PRE-EXAM FORM

6 YEARS – 12 YEARS

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website http://calhounchiropractic.net/

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PEDIATRIC PRE-EXAM FORM (6 years to 12 years)

Appointment Date: _____

Please fill out all information as thoroughly as you can. Thank you.

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Birth Date: _____ Age: _____ Sex: M F

Address: _____ City/State/Zip: _____

Mother's Name: _____ Father's Name: _____

Mother's Phone: ( ) _____ Father's Phone: ( )_____

Parent's Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

Number of Siblings: _____ Sibling(s) Names & Ages: _____

_____

Predominant language used in the home: _____

Who can we thank for referring you to our office? _____

REASON FOR SEEKING CARE

What is the reason for seeking care at Calhoun Chiropractic Wellness Center? _____

_____

When did this begin? (If applicable) _____

What is affecting your child most in life? _____

_____

Has your child seen any other providers for this condition? (list all conditions and the doctor seen):_____

_____

Has your child seen a chiropractor before? ***Yes*** ***No*** If yes, how long ago? _____

Clinic/Doctor Name: _____ What is your reason for the change? _____

_____

What health goal would have the greatest impact on his/her life? _____

_____

PREGNANCY HISTORY

Location of birth: ○ Home ○ Birthing center ○ Hospital ○ Other: _____

The duration of pregnancy in weeks: _____ Birth weight: _____ Birth length: _____Apgar Score: _____

Did any of the following happen during delivery: ○ C-section ○ Doctor pulled or twisted baby ○ Anesthesia

○ Labor was induced ○ Forceps/vacuum extraction ○ Premature delivery ○ Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery: _____

_____

What was the baby's position during pregnancy/birth? ○ Anterior ○ Posterior ○ Breach ○ Transverse ○ Other_____

PREGNANCY HISTORY CONTINUED

Did any of the following happen during pregnancy: ○Falls ○Motor vehicle accident ○High blood pressure ○Anemia ○Gestational diabetes ○Morning sickness ○Indigestion ○Seizures ○Swollen ankles ○Thyroid problems ○Heart problems ○Back pain ○Abnormal bleeding ○Any other illnesses _____

Were any of these used during the pregnancy: ○Tobacco ○Alcohol ○Non-prescribed drugs ○Prescription medications ○Over-the-counter meds ○Other: _____

List any medications being taken: _____

Did your child receive any of the following nutrition? ○Breast milk ○Commercial formula ○Cow's milk ○Goat's milk ○Other milk ○Vitamins ○Medication ○Juice: Vegetable ○Juice: Fruit ○Other: _____

Check when you introduced the following into the child's diet (and using an estimate, at how many weeks):

○Sweets _____○Solid Foods_____ ○Other_____

HEALTH HISTORY

In the past year have any of the following happened?

Health History

Has your child had any upper respiratory infections? ○Yes ○No *How often?* _____

Has your child had asthma? ○Yes ○No *If yes, when and how often/what triggers it?* _____

Does your child complain of back or neck pain? ○Yes ○No *How often?* _____

Does your child complain of pains in the arms or legs? ○Yes ○No *How often?* _____

Does your child complain of headaches? ○Yes ○No *How often?* _____

Has your child had any earaches? ○Yes ○No *If yes, at what age did the first earache occur?* _____

How frequently does your child have earaches? _____

Do the earaches usually tend to occur in the same ear? ○Yes ○No ○Right ○ Left ○ Both

Has your child had any other illnesses? ○Yes ○No *Please list each illness and its approximate date:* _____

_____

Is your child presently taking any prescribed medications? ○Yes ○No Please list: _____

Has your child ever been to a hospital or emergency room for evaluation or treatment? ○Yes ○No

Has your child recently been vaccinated? ○Yes ○No What *vaccinations?* _____

Has there been any past or present medical treatments? ○Yes ○No If *yes, whom did they see and for what reason?*

_____

Is your child still under care for above mentioned treatment? ○Yes ○No If *yes, how often?* _____

Please list any surgeries your child has had: _____

Trauma

Has your child had any recent falls, sprains, strains, or physical, chemical, or emotional trauma? ○Yes ○No
If yes, describe the trauma and date it occurred: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? ○Yes ○No _____

Has your child ever fallen down stairs or fallen from a significant height? ○Yes ○No _____

Has your child ever been in a car accident or near miss? ○Yes ○No _____

Has your child ever had a bone fracture or joint dislocation? ○Yes ○No _____

Has your child had any injuries? ○Yes ○No _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? ○Yes ○No _____

Does your child have problems with bed wetting? ○Yes ○No If *yes, how often?* _____

HEALTH HISTORY CONTINUED

Nutrition

Do you have any concerns about your child's diet? ○Yes ○No *What?* _____

Does your child have any food allergies? ○Yes ○No List *all allergies:* _____

Does your child have any persistent or intermittent skin rashes? ○Yes ○No *If yes, where?* _____

Does your child take any vitamin supplements? ○Yes ○No _____

Does your child eliminate stools each day? ○Yes ○No *How often?* _____

For how many months was your child breast fed? _____ For how many months was your child on formula? _____

What foods does your child eat for breakfast? _____

What foods does your child eat for lunch? _____

What foods does your child eat for dinner? _____

What foods does your child eat as snacks? _____

How much cow's milk does your child drink each day? _____ How much water does your child drink each day? _____

How many sodas or colas do they drink each day? _____ ○Diet ○Regular What *kinds?* _____

What is your child's favorite food? _____ How often do they eat fast food? _____

What type of fast foods or fried foods does your child like to eat? _____

Lifestyle

What grade of school is your child in? _____ How does he/she carry school books? _____

How heavy is his/her school bag in pounds (School bags should only be up to 15% of body weight.)? _____*lbs.*

What sports does he/she play? _____

What hobbies does he/she have? _____

How many hours does he/she do the following: **Watch TV?** _____*hrs./day*_____ *hrs./week* **Use a computer/electronic device?** _____*hrs./day*_____ *hrs./week* **Play video games?** _____*hrs./day*_____ *hrs./week*

About how many hours of sleep do they get each night? _____ On average, what time do they go to sleep at night? _____

Are there smokers in the home? ○Yes ○No

Does your child seem stressed out about anything? _____

Does he/she have trouble reading the board in class? ○Yes ○No Does he/she wear glasses or contact lenses? ○Yes ○No

Does he/she sometimes get headaches from reading? ○Yes ○No

FAMILY MEDICAL HISTORY

Please check if any of your blood relatives have/had any of the following illnesses and mark accordingly by noting: M (mother), F (father), S (sibling), PGM (paternal grandma), MGM (maternal grandma), PGF (paternal grandfather), MGF (maternal grandfather):

_____Allergy ○Have ○ Had
_____Asthma ○ Have ○ Had
_____Eczema ○ Have ○ Had
_____Cancer ○Have ○ Had
_____Low Blood Sugar ○Have ○ Had
_____Heart Trouble ○ Have ○ Had
_____High Blood Pressure ○Have ○Had
_____Stroke○ Have ○ Had
_____Kidney disease ○ Have ○ Had
_____Liver Disease ○Have ○ Had
_____ Mental Retardation ○ Have ○ Had
_____Autism ○ Have ○ Had
_____Mental Illness ○Have ○ Had
_____Scoliosis ○ Have ○ Had
_____Ulcer ○ Have ○ Had
_____Diabetes ○ Have ○ Had

Please list all blood relatives who have deceased, the cause of death, and their age of death:

_____

_____

OTHER

Any other information or concerns about your child's health:

_____

_____

_____

_____

CONSENT TO TREAT

Who is/are the legal guardian(s) of this child? _____

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine, x-ray (if necessary), and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's signature: _____ Date: _____

Witnessed by: _____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I am the legal guardian of the child noted here.**

Initials _____ **I give permission to the providers of Calhoun Chiropractic Wellness Center to provide care for my child noted in lieu of my absence.**

Initials _____ **I instruct the Doctor of Chiropractic to deliver the care that, in his or her professional judgment, can best help my child in the restoration of his/her health. I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my child's health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my child's care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my child's concern.**

Initials _____ **I understand that the doctors at Calhoun Chiropractic Wellness Center will be providing my child with chiropractic treatment. I fully understand that there is no guarantee that such treatment/care will improve his/her condition. Many practice members have over the years been treated by chiropractors for various conditions, some of which respond to treatment, and others which may not, despite the best of care. I understand that it is my responsibility to keep an open line of communication with my doctor as to how he/she is progressing. Chiropractic treatment by nature often involves frequent office appointments in order to maximize the benefits of the care.**

Initials _____ **I give the doctors at Calhoun Chiropractic Wellness Center my consent to take any and all x-rays needed to better understand my child's condition. I have been fully informed of the possible risks and safety standards of this office. If I am aware of any contraindications to x-rays for my child I will discuss with the doctor(s) prior to them being taken.**

Print Practice Member Name: _____

Relationship to Practice Member: _____

Parent/Guardian Signature: _____

Date: _____

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Patient Birth Records Release

I, _____, parent (or legal guardian) of the below mentioned child, hereby authorize and direct _____ (pediatrician's name) to release the records relating to the birth of _____, to Calhoun Chiropractic Wellness Center noted above. May this signed consent form be your good authority to do so.

Your Date of Birth (MM/DD/YYYY): _____/_____/_____
Your Child's Date of Birth (MM/DD/YYYY): _____/_____/_____

Your Name: _____ Date: _____

Your Signature: _____

Witness: _____ Date: _____

Thank You! We are grateful you have chosen to bring your child to Calhoun Chiropractic Wellness Center, and look forward to being part of your family's wellness journey.