

# Pediatric Life Story

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## Vital Information

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parents'/Guardians' Names: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/St/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Cell Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Work Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Height (of child): \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Siblings and ages: \_\_\_\_\_

Previous Chiropractic Care?  Yes  No

### Emergency Contact

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternative phone number: \_\_\_\_\_

### Family Doctor

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

### Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, PT, OT, Speech Pathologist, Massage Therapist, Behavioral Therapist, etc.)

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

Child's Name: \_\_\_\_\_

**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 may 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 the **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**.

**What signals has your child's body been communicating?**

Previously ↓ Currently	Previously ↓ Currently	Previously ↓ Currently
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Failure to Thrive/ Slow Weight Gain
<input type="checkbox"/> <input type="checkbox"/> Respiratory Tract Infections	<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Slow or Absent Reflexes
<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <input type="checkbox"/> Flatulence	<input type="checkbox"/> <input type="checkbox"/> Asymmetrical Crawling or Gait
<input type="checkbox"/> <input type="checkbox"/> Ear Infections	<input type="checkbox"/> <input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> <input type="checkbox"/> Weight Challenges
<input type="checkbox"/> <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> Strep Throat	<input type="checkbox"/> <input type="checkbox"/> Torticollis / Head Tilt	<input type="checkbox"/> <input type="checkbox"/> Sleep Problems
<input type="checkbox"/> <input type="checkbox"/> Frequent Colds/ Croup	<input type="checkbox"/> <input type="checkbox"/> Trouble Feeding on one side	<input type="checkbox"/> <input type="checkbox"/> Night Terrors
<input type="checkbox"/> <input type="checkbox"/> Recurrent Fevers	<input type="checkbox"/> <input type="checkbox"/> Back Pain	<input type="checkbox"/> <input type="checkbox"/> Tip Toe Walking
<input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> Growing Pains	<input type="checkbox"/> <input type="checkbox"/> Sensory Processing Issues
<input type="checkbox"/> <input type="checkbox"/> Rashes	<input type="checkbox"/> <input type="checkbox"/> Scoliosis	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Red, Swollen, Painful Joint	<input type="checkbox"/> <input type="checkbox"/> Tremors / Shaking
<input type="checkbox"/> <input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> <input type="checkbox"/> Colic	<input type="checkbox"/> <input type="checkbox"/> ADD / ADHD
<input type="checkbox"/> <input type="checkbox"/> Digestive Problems	<input type="checkbox"/> <input type="checkbox"/> Frequent crying spells	<input type="checkbox"/> <input type="checkbox"/> Autism / SPD

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? \_\_\_\_\_ For how long? \_\_\_\_\_

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

Child's Name: \_\_\_\_\_

Have you seen other health professionals regarding this complaint?

No  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  Birth 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 birth? \_\_\_\_\_ hours.

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

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

Any concerns about mis-shapen head at birth?  No  Yes

**Post Natal & 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? \_\_\_\_\_

Child's Name: \_\_\_\_\_

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 swings, 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  Stomach  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 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 to vaccinate: \_\_\_\_\_

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

Fatigue  Seizures  Prolonged Cry  Development 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 past 6 months? \_\_\_\_\_ Reason: \_\_\_\_\_

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

If yes, which ones? \_\_\_\_\_

If yes, how many doses in past 6 months? \_\_\_\_\_ Reason: \_\_\_\_\_

Child's Name: \_\_\_\_\_

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 second hand 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? \_\_\_\_\_

### Emotional Stressors

Does your child seem happy?  No  Yes

Does your child show signs of depression or sadness?  No  Yes

Does your child show signs of anxiousness or anxiety?  No  Yes

Does your child participate in sports or extracurricular activities?  No  Yes

Does your child have a high quality group of friends who have involved parents?  No  Yes

Does your family have regular family meals?  No  Yes

Has your child experienced bullying?  No  Yes

If yes, share what action steps have been performed: \_\_\_\_\_

### AUTHORIZATION FOR CARE OF A MINOR

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to check and adjust when appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

Parent or Guardian Authorizing Care Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

## **NOTICE OF HEALTH CARE AUTHORIZATION & PRIVACY POLICY**

I have been offered but have not made a request to review a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. You can request a copy of the Privacy Practices in its entirety at any time. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to Healing Touch to conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care.
- I give permission to use my physical address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If Healing Touch Chiropractic contacts me by my phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to Healing Touch Chiropractic to use my name and photograph on their welcome board, referral board, bulletin board and other informational material such as their brochure, website, social media sites and articles in print media.
- I give permission to Healing Touch to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, or their website, or in ads in print media.
- I give Healing Touch Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other person in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
- Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.
  - You may request restrictions on your disclosures
  - You may inspect and receive copies of your records within 30 days of a request
  - You may request to view changes to your record

By signing this form you are giving Healing Touch Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your Healing Touch Chiropractic more efficient and productive as well as to enhance your access to quality of Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Healing Touch Chiropractic plus 7 years unless revoked by me. I also understand that I can request, in writing, that you are restricting how my personal information is used and/or disclosed.

I have read and understand this Healthcare Form. My signature below represents agreement with these practices.

Name of Parent or Guardian (Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**OUR FEE STRUCTURE AND FINANCIAL POLICY**

Please note our fees for your initial visit:

Consultation, exam and nervous system scan: \$150

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Also, note that the Report of Findings, the time that your doctor will spend with you to go over your results, is part of the initial visit fee. Recommendations for care are based on necessity and not insurance benefits. We are a cash office and are not in network with any insurance companies.

*I CLEARLY UNDERSTAND AND AGREE that I am responsible for all the bills incurred at this office relating to my care. I also understand that if I suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable.*

I \_\_\_\_\_ have completely read and understood the above statement concerning fees and choose to receive care.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_