2114 Schofield Ave.
Weston, WI 54476

CONFIDENTIAL PEDIATRIC HEALTH RECORD

NEW PATIENT ❏
REACTIVATE ❏
OTHER ❏

PLEASE PRINT: DATE:____________

CHILD'S FULL NAME____________ PARENT'S HOME PHONE____________
PARENT'S FULL NAME____________ PARENT'S WORK PHONE____________
PARENT'S STREET/P.O. ADDRESS____________
CITY/STATE/ZIP____________
WHAT IS YOUR CHILD'S BIRTHDATE?________ HOW OLD IS YOUR CHILD?______ CHILD'S S.S.#____________

HISTORY OF THE PRESENT ILLNESS/INJURY

PLEASE BE SPECIFIC:

CHIEF COMPLAINT

PLEASE DESCRIBE YOUR CHILD'S PAIN OR CONDITION

FOR WHAT CONDITION ARE YOU CONSULTING THE DOCTOR? ____________
____
____
WHEN DID IT BEGIN?____________
SINCE THAT TIME, HAS THE PROBLEM BECOME ❏ BETTER ❏ WORSE ❏ STAYED THE SAME?
HOW DID IT OCCUR?____________
DO THE SYMPTOMS CHANGE WITH THE TIME OF DAY? CONSTANT, COMES AND GOES____________
LIST ANY VISIBLE BUMPS, SCRAPES, CUTS, ETC. ON YOUR CHILD:____________
____

YES	NO	
❏	❏	HAS THERE BEEN A CHANGE IN YOUR CHILD'S EATING HABITS? IF SO, WHAT?____________
❏	❏	HAS THERE BEEN A CHANGE IN YOUR CHILD'S SLEEPING HABITS? IF SO, WHAT?____________
❏	❏	DOES YOUR CHILD CRY IF A PARENT ATTEMPTS TO CHANGE HIS/HER SLEEPING POSITION?____________
❏	❏	DOES YOUR CHILD WAKE UP AND CRY FREQUENTLY AT NIGHT?____________
❏	❏	ARE THERE ANY OTHER ALTERATIONS OF YOUR CHILD'S NORMAL SLEEP PATTERNS?____________
❏	❏	DOES YOUR CHILD HAVE A FEVER OF UNKNOWN ORIGIN?____________
❏	❏	DOES YOUR CHILD HAVE A LOSS OF APPETITE OR OTHER RECENT EATING DISORDERS?____________ ____________
❏	❏	DOES YOUR CHILD HAVE A RECENT CHANGE IN "BATHROOM" HABITS?____________
❏	❏	HAS YOUR CHILD RECENTLY BECOME IRRITABLE / RESTLESS / GRUMPY, ETC.?____________

WHAT MAKES THE CONDITION BETTER?

HEAD NECK____________
MID BACK____________
LOW BACK____________
SHOULDER, ARM, HAND____________
HIP, LEG, FOOT____________
OTHER____________

WHAT MAKES THE CONDITION WORSE?

HEAD NECK____________
MID BACK____________
LOW BACK____________
SHOULDER, ARM, HAND____________
HIP, LEG, FOOT____________
OTHER____________

PAST MEDICAL HISTORY

YOUR CHILD'S BIRTH:

WAS THE CHILD'S DELIVERY ❏ VAGINAL OR ❏ CESAREAN?____________
WAS THE CHILD BORN ❏ HEAD DOWN ❏ BREECH OR ❏ SHOULDER DOWN?____________
❏ YES ❏ NO WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED DURING DELIVERY? ____________
❏ YES ❏ NO WAS LABOR PROLONGED? HOW LONG WAS LABOR?____________
❏ YES ❏ NO WAS THERE MORE THAN ONE BABY? ____________

YES	NO	
❏	❏	HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE? WHEN?____________
		DOCTOR'S NAME AND LOCATION:____________
		FOR WHAT CONDITION?____________
		HOW MANY TIMES HAVE YOU HAD THIS CONDITION BEFORE? ❏ 0-3 TIMES? ❏ 4 OR MORE TIMES?
❏	❏	HAS YOUR CHILD EVER SEEN ANYONE ELSE FOR THIS CONDITION? WHEN?____________
		WHERE TREATED?____________ BY WHOM?____________
		RESULTS:____________ DIAGNOSIS:____________

YES NO

❏ ❏ ALLERGIES? TO WHAT?________________________________

❏ ❏ DOES YOU CHILD TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?

❏ ❏ HAS YOUR CHILD EVER BEEN IN AN AUTOMOBILE ACCIDENT?

WHEN?________ WAS ANYTHING INJURED? ❏ NO ❏ YES, WHAT?________________

HOW WAS IT TREATED?________________________

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) ________________

❏ YES ❏ NO WAS YOUR CHILD RIDING IN A CHILD SEAT? ________________

WAS THE SEAT IN THE ❏ REAR SEAT ❏ FRONT SEAT, FACING ❏ FORWARD OR ❏ BACKWARD?________

❏ YES ❏ NO WAS YOU CHILD IN A BOOSTER SEAT? ________________

❏ YES ❏ NO DOES YOUR CAR HAVE AIR BAGS? ________________

WAS YOUR VEHICLE STRUCK FROM THE ❏ REAR ❏ FRONT ❏ LEFT SIDE OR ❏ RIGHT SIDE?________

❏ ❏ HAS YOUR CHILD EVER HAD ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS OR SURGERIES?

FIRST: WHEN?________ WHAT WAS INJURED?________________

HOW WAS IT TREATED?________________________

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY) ________________

SECOND: WHEN?________ WHAT WAS INJURED?________________

HOW WAS IT TREATED?________________________

RESULTS OF TREATMENT: (COMPLICATIONS, COMPLETE RECOVERY)________________

❏ ❏ HAS YOUR CHILD HAD X-RAYS? WHEN?____________ WHAT BODY PARTS?________________.

FAMILY HEALTH HISTORY

HEALTH STATUS (IF DECEASED, FROM WHAT?)

MOTHER:________________________________

FATHER:________________________________

SISTERS:________________________ HOW MANY ________

BROTHERS:________________________ HOW MANY________

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES AND N FOR NO IN EACH OF THE FOLLOWING:)

1. ___ EYES
2. ___ EARS, NOSE, MOUTH, THROAT
3. ___ HEART
4. ___ LUNGS/BREATHING
5. ___ INTESTINES
6. ____ URINARY
7. ____ MUSCLES
8. ____ NERVES
9. ____ SKIN
10. ____ PSYCHOLOGICAL
11. ____ INTERNAL ORGANS
12. ____ BLOOD
13. ____ ALLERGIES
14. ____ OTHER________________

PLEASE DESCRIBE:________________________________

ADDITIONAL CONCERNS/COMMENTS:

HOW DID YOU HEAR ABOUT US?

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT SIGNATURE:________________________ DATE:____________

GUARDIAN SIGNATURE:________________________ DATE:____________

D.C./C.A. SIGNATURE:________________________ DATE:____________

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefor it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be full informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care:

Stroke– Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located withing the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).

Soreness– Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While is is not general dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury– Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury– Manual adjustments to the thoracic spine, in rare cases, May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns– Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems– There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is your goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have Dr. _____________________________ and/or whomever he/she may designate as his/her assistants to examine, x-ray and administer chiropractic care to my child as he/she deems necessary, in my presence or absence.

Patient's Name Printed ______________________________

Today's Date ______________________________

Witness ______________________________

Parent of Guardian Signature for Minor ______________________________