Positively CHIROPRACTIC
PREGNANCY, FAMILY, PEDIATRIC

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine, and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Pediatric Information

Child's Name: _____ S.S. # _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Parent's Cell: _____ Parent's Email: _____
Date of Birth: _____ Current Age: _____ Sex: _____ Weight: _____ Height: _____ft. _____in.
Parent/Guardian _____ Relationship to Child: _____
How did you hear about our office? _____

Health History

Reason for pursuing care (circle one): *Maintenance* *Improved Health* *Problem(s):* _____
Other doctors seen for this condition(s)? *Y/N* Doctors' Names: _____
Prior Treatment: _____ Current Treatment: _____
List any other health problems: _____

Check any of the following conditions that currently apply:

- ☐ ADHD/ADD
- ☐ Allergies
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Colic
- ☐ Constipation
- ☐ Chronic Colds
- ☐ Digestive Problems
- ☐ Ear Infections
- ☐ Growing/Back Pains
- ☐ Headaches
- ☐ Recurring Fevers
- ☐ Scoliosis
- ☐ Seizures
- ☐ Temper Tantrums
- ☐ Other: _____

Has your child been in a car accident? If so, when? _____
Previous Chiropractic Care? Chiropractor's Name: _____ Last Visit Date: _____
Name of Pediatrician: _____Location: _____ Last Visit Date: _____
How satisfied are you with the care your child has received at the pediatrician: *Very* *Somewhat* *Dissatisfied*
How many doses of antibiotics has your child taken: In the past 6 months: _____ Total Lifetime: _____
Current prescription drugs/dosages: _____
Current vitamins/dosages: _____
Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____ How often? _____
Has your child had vaccines? *Y/N* Most Recent vaccine(s): _____ When? _____

Prenatal History

Name of Obstetrician/Midwife: _____ Ultrasounds during pregnancy? *Y/N* How Many? _____
Location of Birth: _____ Birth Weight: _____ Birth Length: _____ APGAR Scores: ___-____
Explain any complications during pregnancy/delivery: _____
List any medications taken during pregnancy/delivery: _____
Cigarette/Alcohol use during pregnancy? *Y/N* List any genetic disorders/disabilities: _____
Birth Intervention: *Forceps* *Vacuum Extraction* *Planned C- Section* *Emergency C-Section*

Feeding and Developmental History

Brest Fed: *Y/N* How Long? _____ Formula Fed: *Y/N* How Long? _____ Type: _____
When was your child introduced to: Solid Foods @ _____ Months; Cow's milk @ _____ Months
List food/Juice allergies/intolerances: _____

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Please indicate the age your child was able to accomplish the following activities.
Respond to stimuli _____ Respond to visual stimuli _____ Cross crawl _____ Stand alone _____
Sit up _____ Hold head up _____ 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. a bed, changing table, down stairs, etc.) If your child had a fall similar to what was described above, please explain: _____
List any sports your child has been involved in: _____
Has your child been seen by a physician for an emergency, please explain: _____
_____ Name/Location of Physician: _____
Please list any other trauma your child as experienced: _____

Does your child (cirlce all that apply): *Eat 3-4 Servings of Veggies Daily* *Drink PURE Water Daily*
Go Outside Daily *Watch TV Daily* *Play Video/Computer Games Daily*
What are your child's hobbies/interests? _____
Is there anything else you would like us to know about your child? _____

Consent to Care for a Minor

If this health intake form is for a minor/child, please fill out and sign below.
Name of patient who is a minor/child: _____ Date of birth of minor: _____
I AUTHORIZE DR. ERIN CLIFTON, DR. SARAH PRATER-MANOR, AND ALL POSITIVELY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY POSITIVELY CHIROPRACTIC.

Guardian Signature: _____ **Date:** _____ **Relationship to minor:** _____
Witness Signature (Staff): _____ Date: _____

Doctor's Notes

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Our Privacy Pledge

Here at Positively Chiropractic, we are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for care or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosure: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to authorization: You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revote authorization. If you were required to file your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

*I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this form.

Printed Name: _____ Signature: _____ Date: _____

Authorized Provider Representation: _____ Date: _____