Essentials of Life Chiropractic

Pediatric Health Questionnaire (Ages 12 and Under)

Name of Child: _____ Today's Date_____ Birthdate _____

Male ☐ Female ☐ Name of Parents:_____

Address_____
Residence and mailing City State Zip Code

Best Contact Number: (_____)_____ E-mail address_____@_____

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

HEALTH HISTORY

Reason for seeking care in our office _____

_____

Any other concerns?_____

When was your child's last fall or trauma?_____ Was any care given? _____

Was he / she checked by a chiropractor? Y / N

Has your child ever fallen from heights of over 2 feet or had any falls down steps? Y / N If yes, please describe: _____

_____

Has your child ever been seen on an emergency basis? Y / N If yes, please describe: _____

_____

Please list all past and present athletic activities your child has participated in: _____

Has your child ever been involved in an automobile accident? Y / N

Are you concerned about any developmental delays? If so, please explain:_____

List any current medications or supplements: _____

On a scale of 0-10, please describe your child's stress level (0=None / 10=Extreme): _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOUR CHILD HAS SUFFERED FROM IN THE PAST OR PRESENT

☐ Allergies	☐ Digestive Problems	☐ Neck Pain
☐ Asthma	☐ Ear Infections	☐ Poor Posture
☐ ADHD/ADD	☐ Fatigue	☐ Rashes
☐ Back Pain	☐ Fevers	☐ Reflux
☐ Bedwetting	☐ Growing Pains	☐ Rubella
☐ Breathing Problems	☐ Headaches	☐ Seizures
☐ Chicken Pox	☐ Irritability	☐ Scoliosis
☐ Colds	☐ Measles	☐ Sleeping Disorders
☐ Colic	☐ Meningitis	☐ Whooping Cough
☐ Diarrhea	☐ Mumps	☐ (other)_____

HIPAA: Consent for Use for Disclosure of Health Information

In compliance with federal law, a copy of the national Standards for Privacy of Individually Identifiable Health Information is available upon request. The Privacy Notice describes in detail how a member's health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of a member's health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail. A copy of the Privacy Notice has been made available to me.

When member is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Parent/Guardian_____

Name of Child_____

Date_____

For Doctor's Use Only

_____

_____

_____

_____

Essentials of Life Chiropractic

1777 Bunker Lake Blvd NW#200
Andover, MN 55304
763-413-6934

Informed Consent for Chiropractic Care

When a person seeks chiropractic health care and we accept him or her as a patient, it is essential for both to be working toward the same objective. It is important that each member understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

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