Anatomy Power Pediatric Chiropractic

Chiropractic Care for your Children   *Date:*________________________________

Consent to Treat a Minor

Child's Name: ______________________________
Parent's Name: ______________________________
Parent's Consent/Signature: ____________________

Address: ___________________________________
City: ______________________________________
State/Zip: __________________________________
Parent's Email: ______________________________

Child's Birthdate: ____________________________
SSN: ______________________________________

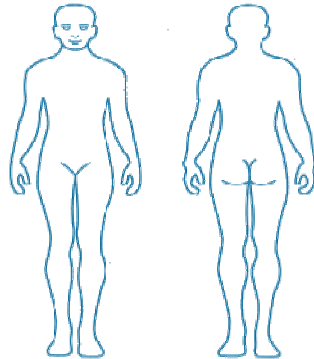
Child's Condition

Reason for visit?______________________________
____
Behavioral changes? ___________________________
____

Is this condition getting worse? __Yes __No

Mark an X on the picture where the child has pain, redness, or rash.

Mark any postural signs of stress (head tilt, arm or leg tension).



Type of pain: __Sharp __Dull __Burning
__Tingling __ Stiffness __Cramps __Swelling
__Constipation __ Rash __ Redness __ Colic
__Other: _____________________________________

How often does it occur? _______________________
Is it constant or does it come and go? ____________
What treatments have you tried for this condition?
____

Does it interfere with: __School __Recreation
__Sleep __Daily Routine __Other: ______________

Activities that are painful to perform:
__Sitting __Standing __Walking __Bending

Parent's Phone Numbers

Cell Phone: (_____) ____________________
Home Phone: (_____) ____________________
Work Phone: (_____) ____________________
Emerg Contact: (_____) ____________________
Emerg Contact Name: _______________________

Family History

Please check any that apply to your family:
__Cancer __Seizure __Kidney __Disease __Diabetes
__Heart Disease __High Blood Pressure __Ulcers
__Osteoarthritis __Alcoholism __ Arthritis __Other

Insurance Information

Who is responsible for this account? ____________
Relationship to Patient: ______________________
Insurance Company: _________________________
Group #: __________________________________

Assignment and Release

I certify that I have healthcare insurance with [Company Name] ______________________________
and assign directly to Anatomy Power all insurance benefits, if any otherwise payable ot me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent or Guardian

____
Please print name of Patient, Parent or Guardian

_________   _________________________
Date   Relationship to Patient

Accident Information

Is this condition due to an accident? __Yes __No
Date of the accident: _________________________
Type of accident: __Auto __Home __Other
To whom have you made a report of the accident?
__Auto Insurance __ M.D. __ School

HEALTH HISTORY

PRENATAL / NEONATAL

Describe your pregnancy: 1st, 2nd, 3rd trimester details:____
Illness/Problems during pregnancy:____
Labor/Delivery (vaginal, c-section, forceps, vacuum, complications):______________________________
Hours in labor:______________________________________ Hours pushing:_______________________
Delivery– location:__________________________________ Care provider:_______________________
Drugs used during pregnancy/labor:____________________ APGAR Score:________________________
Neonatal health issues (jaundice, respiratory prob., infections, digestion):___________________________

NUTRITION INFORMATION

Breast fed:____Bottle fed:____Other:_________
Feeding schedule:_________________________
Intro to solid foods: age______ foods_________
Food allergies:____________________________
Favorite foods:____________________________
Feeding problems (regurgitation, colic):_______
Appetite & attitude during meals:____________
Use of supplements:_______________________

MEDICAL SURVEY

Immunizations & ages:_______________________
Reactions to immunizations:___________________
Childhood diseases:__________________________
Number of ear infections:_____________________
Allergies/Sensitivities:_______________________
Injuries/fractures/hospitalizations:________________
____

FAMILY INFORMATION

Mother– age:______ health status:____________
Father– age:______ health status:_____________
Siblings– ages:______ health status:__________
Family dynamics (who is in the household?):
____
Bedtime:________ Wake-up time:___________
Daily schedule (school/daycare, activities, meals):
____

GROWTH & DEVELOPMENT

Birth weight:_________ Birth length:____________
Age at: head control_____, smile_____, crawl_____,
sitting____, standing____, first words___, other____
Sleep patterns:________________________________
Toilet training (bedwetting) ____________________
Other habits (thumb sucking, rocking):____________
____
Discipline (tantrums, withdrawal, listening):________
____
Socialization (school/daycare, activities):__________

TRAUMA

Please describe any that apply to your child:

Falls ____ Date ___________________
Head Injuries ____ Date ___________________
Broken Bones ____ Date ___________________
Disocations ____ Date ___________________

MEDICATIONS FOODS DAILY VITAMINS

Drug Name:	Condition being treated:		
________________	____________________	_______________________	_____________________
________________	____________________	_______________________	_____________________
________________	____________________	_______________________	_____________________
________________	____________________	_______________________	_____________________
________________	____________________	_______________________	_____________________
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