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: _____

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

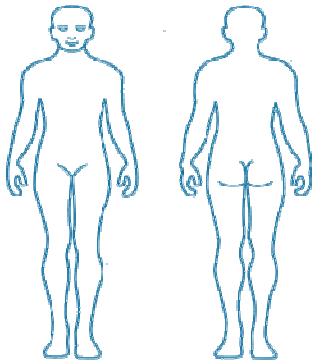
Child's Condition

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

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

Drug Name:	Condition being treated:

FOODS DAILY

VITAMINS