nexus
FAMILY CHIROPRACTIC

File _____

PEDIATRIC HEALTH HISTORY

Welcome to Nexus Family Chiropractic. Please fill out this form to the best of your ability to help speed up your office visit, and to allow us to better serve your healthcare needs. If there are any sections that do not apply, simply write "N/A" and move on to the next section

Date _____

Child's Personal Information

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State ____ Zip _____

Names and Ages of Siblings _____

Parent A Information

Name _____

Phone (H) _____

Phone (C) _____

Employer _____

Phone (W) _____

Email _____

Parent B Information

Name _____

Phone (H) _____

Phone (C) _____

Employer _____

Phone (W) _____

Email _____

Parent ❒ A ❒ B Social Security # _____

Whom can we thank for referring you to our office? _____

Health Care Practitioner History

Has your child ever received chiropractic care? ❒ Yes ❒ No Name of D.C. _____

Reason for care _____ How long? _____ Date of last visit _____

How did they respond with care? _____

Have you ever consulted or do you regularly consult with any of the following providers for your child?

Check all that apply: ❒ Naturopath ❒ Acupuncturist ❒ Homeopath ❒ Energy Healer

❒ Psychotherapist ❒ Massage Therapist ❒ Other

Pediatrician's name _____ Date of last visit _____

Reason for Seeking Chiropractic Care

Does your child have a present Complaint or Concern? If no current complaint, what is the reason for the visit today?

_____

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When did this condition begin? _____

Is the condition: ❒ Getting Worse ❒ Improving ❒ Constant ❒ Intermittent ❒ Unsure

How did the condition start? ❒ Suddenly ❒ Gradually ❒ Post-Injury ❒ Auto Accident

What makes the condition better? _____

What makes the condition worse? _____

Has your child ever had a similar condition before? ❒ Yes ❒ No Please explain _____

Is this condition interfering with: ❒ School ❒ Sleep ❒ Playing ❒ Walking ❒ Eating
❒ Attention/Focus ❒ Exercise/Sports ❒ Communication

If so, please explain _____

Has your child been seen for this condition? ❒ Yes ❒ No

If so, please explain _____

Please check if your child has experienced any of the following conditions:

❒ ADHD	❒ Constipation	❒ Frequent Colds/Flus	❒ Scoliosis
❒ Asthma	❒ Dental Problems	❒ Growing Pains	❒ Seizures
❒ Allergies	❒ Digestive Problems	❒ Irritability	❒ Sleeping Problems
❒ Auto Accident	❒ Depression	❒ Loss of Balance	❒ Sensitivity to Light
❒ Bed Wetting	❒ Ear Infections	❒ Poor Coordination	❒ Vision Changes
❒ Behavioral Problems	❒ Fainting	❒ Poor Posture	❒ Walking Trouble
❒ Colic	❒ Fatigue/Low Energy	❒ Recurring Fever	

Other _____

Pregnancy and Birth

Our ❒ Obstetrician ❒ Midwife ❒ Family Physician was _____

During pregnancy, did you/the mother:

Experience any significant illnesses, difficulties, or trauma? ❒ Yes ❒ No If yes, please explain _____

_____

Take any drugs/medications/supplements? ❒ Yes ❒ No If yes, please explain _____

_____

Smoke or consume alcohol? ❒ Yes ❒ No

Any exposure to ultrasound? ❒ Yes ❒ No If yes, how many and what was the medical reason? _____

_____

Was the delivery premature? ❒ Yes ❒ No Weeks _____ Weight _____

Approximately how long did labor last? _____ hours

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What was the birth process like? ❒ Vaginal ❒ Medications ❒ Forceps ❒ Caesarian ❒ Breach ❒ Episiotomy
❒ Epidural ❒ Induced ❒ Home or water birth ❒ Vacuum extraction

Please list reasons for any interventions/complications _____

Does your child have any genetic disorder or disabilities? ❒ Yes ❒ No If yes, please explain _____

_____

Growth and Development

Was your child alert and responsive within 12 hours of delivery? ❒ Yes ❒ No

If no, please explain _____

Child's birth weight _____ Child's birth length _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

At what age did your child:

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____

Sit alone _____ Teethe _____ Crawl _____ Stand alone _____ Walk _____

Is/was your child breastfed? ❒ Yes ❒ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solids at age _____

Please list any foods/juice intolerance _____

If breastfed, any difficulty with breastfeeding? ❒ Yes ❒ No ❒ N/A If yes, please explain _____

_____

Any difficulty with bonding? ❒ Yes ❒ No If yes, please explain _____

_____

Any behavioral problems? ❒ Yes ❒ No If yes, please explain _____

_____

Any night terrors, sleep walking or difficulty sleeping? ❒ Yes ❒ No If yes, please explain _____

_____

Please list any non-prescription or prescription drugs or medication your child is taking? _____

_____

Has your child had surgery or been hospitalized? ❒ Yes ❒ No Please explain why and when _____

_____

What side effects has your child experienced from the drugs and surgery? _____

Have you chosen to vaccinate your child? ❒ Yes ❒ No

If yes, please check all vaccinations your child has received. On the blank line, please state at what age they were administered: ❒ Hepatitis _____ ❒ DPT _____ ❒ MMR _____

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❒ Chicken Pox _____ ❒ Flu _____ ❒ Other _____

Please describe any and all reactions to vaccine(s) _____

Does your child eat well? ❒ Yes ❒ No Does your child have regular bowel/bladder movements? ❒ Yes ❒ No

Injury and Medical History

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. bed, changing table, down stairs, etc.). Was this the case for your child? ❒ Yes ❒ No

Has your child ever been involved in a car accident? ❒ Yes ❒ No If yes, please explain _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has had in his/her lifetime, including this year

_____

_____

In/Out-Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including this year)

_____

_____

Please indicate if your child has ever or currently experiences any of the emotional stresses below: (check all that apply)

❒ Academic pressure ❒ Loss of a loved one ❒ Bullying ❒ Relocation

❒ Lifestyle change ❒ Parents' divorce ❒ Loss of a pet ❒ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❒ Yes ❒ No

Age child began daycare? _____ ❒ N/A Average number of hours of TV/computer per week? _____

Are there any other health concerns or anything else you'd like us to know about your child? _____

_____

I would like my child to experience the following benefits from Chiropractic care (Please check all that apply)

- ❒ Feel better quickly
- ❒ Correct the cause of a problem as well as relief
- ❒ Prevent future problems
- ❒ Live a healthier lifestyle
- ❒ Healthier spine and nervous system
- ❒ Optimal health on all levels

Thank you for trusting us at Nexus Family Chiropractic to connect you and your family to health, happiness, and longevity.

_____ _____

Signature Date

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care for my child on this basis.

Child's Name: (printed) _____

Parent/Legal Guardian's Name: (printed) _____

_____ _____

Signature Date

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Consent to Care

I do hereby authorize the doctor of Nexus Family Chiropractic to administer chiropractic care that is necessary for my child's particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my child's health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also clearly understand that if I do not follow the doctors specific recommendations at Nexus Family Chiropractic that I will not receive the full benefit from the services, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, Nexus Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. Nexus Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand, and hereby request chiropractic care for my child based on the terms of acceptance and the consent to care.

Your Name: (Printed) _____

Signature _____ Date: _____

Healthcare Authorization

The following authorizes Nexus Family Chiropractic to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Nexus Family Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related-emails and information about treatment alternatives or other health related information, as well as my advertisements, newsletters, or patient of the week/month postings.

I give permission to Nexus Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during my treatment. Should I need to speak with a doctor in private, the doctor will provide a private room for these conversations.

By signing the following you are giving Nexus Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices

that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: * The right to review the notice prior to signing this consent * The right to object to the use of my health care information for directory purpose * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations