# Pediatric Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ☐ Yes ☐ No
- If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

## CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Has your child ever received care for this condition before? ☐ Yes ☐ No
- If yes, please explain:

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem better? What makes the problem worse?

## HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

☐ Resolve existing condition
☐ Overall wellness
☐ Both

Have you ever visited a chiropractor? ☐ Yes ☐ No If yes, what is their name?

What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation-based ☐ Other:

## PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ☐ Yes ☐ No If yes, please explain: _____

Did mother smoke? ☐ Yes ☐ No If yes, how many per week? _____

Did mother drink? ☐ Yes ☐ No If yes, how many per week? _____

Did mother exercise? ☐ Yes ☐ No If yes, please explain: _____

Was mother ill? ☐ Yes ☐ No If yes, please explain: _____

Any ultrasounds? ☐ Yes ☐ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

## LABOR & DELIVERY HISTORY

Child's birth was: ☐ Natural vaginal birth ☐ Scheduled C-section ☐ Emergency C-section At how many week's was your child born?

Child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

## GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? Difficulty with breastfeeding? ☐ Yes ☐ No

Did they ever use formula? ☐ Yes ☐ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ☐ Yes ☐ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ Yes ☐ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

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

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ☐ Yes ☐ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ☐ Yes ☐ No If yes, please explain:

Behavioral, social or emotional issues? ☐ Yes ☐ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

## ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: / /

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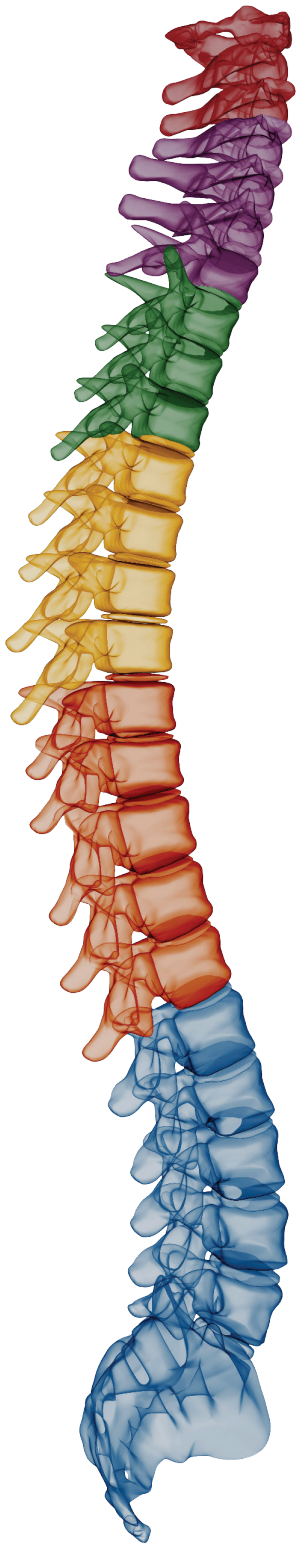
# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.*



| REGIONS | FUNCTIONS | SYMPTOMS | | | |
|---|---|---|---|---|---|
| | | PAST | PRESENT | PAST | PRESENT |
| **Cervical** | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐ | ☐ Colic & Excessive Crying | ☐ | ☐ Epilepsy & Seizures |
| | | ☐ | ☐ Ear & Sinus Infections | ☐ | ☐ Sensory & Spectrum |
| | | ☐ | ☐ Allergies & Congestion | ☐ | ☐ ADD / ADHD |
| | | ☐ | ☐ Immune Deficiency | ☐ | ☐ Focus & Memory Issues |
| | | ☐ | ☐ Headaches & Migraines | ☐ | ☐ Anxiety & Stress |
| | | ☐ | ☐ Vertigo & Dizziness | ☐ | ☐ Balance & Coordination |
| | | ☐ | ☐ Sore Throat & Strep | ☐ | ☐ Speech Issues |
| | | ☐ | ☐ Swollen Tonsils & Adenoids | ☐ | ☐ TMJ / Jaw Pain |
| | | ☐ | ☐ Vision & Hearing Issues | ☐ | ☐ Stiff Neck & Shoulders |
| | | ☐ | ☐ Low Energy & Fatigue | ☐ | ☐ Depression |
| | | ☐ | ☐ Difficulty Sleeping | ☐ | ☐ High Blood Pressure |
| | | ☐ | ☐ Pain, Numbness & Tingling in Arms to Hands | ☐ | ☐ Poor Metabolism & Weight Control |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function | ☐ | ☐ Reflux / GERD | ☐ | ☐ Bronchitis & Pneumonia |
| | | ☐ | ☐ Chronic Colds & Cough | ☐ | ☐ Functional Heart Conditions |
| | | ☐ | ☐ Asthma | | |
| **Mid Thoracic** | • Major Digestive Center<br>• Detox & Immunity | ☐ | ☐ Gallbladder Pain / Issues | ☐ | ☐ Indigestion & Heartburn |
| | | ☐ | ☐ Jaundice | ☐ | ☐ Stomach Pains & Ulcers |
| | | ☐ | ☐ Fever | ☐ | ☐ Blood Sugar Problems |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐ | ☐ Behavior Issues | ☐ | ☐ Allergies & Eczema |
| | | ☐ | ☐ Hyperactivity | ☐ | ☐ Skin Conditions / Rash |
| | | ☐ | ☐ Chronic Fatigue | ☐ | ☐ Kidney Problems |
| | | ☐ | ☐ Chronic Stress | ☐ | ☐ Gas Pain & Bloating |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐ | ☐ Constipation | ☐ | ☐ Sciatica & Radiating Pain |
| | | ☐ | ☐ Chrohn's, Colitis & IBS | ☐ | ☐ Lumbopelvic / SI Joint Pain |
| | | ☐ | ☐ Diarrhea | ☐ | ☐ Hamstring Tightness |
| | | ☐ | ☐ Bed-wetting | ☐ | ☐ Disc Degeneration |
| | | ☐ | ☐ Bladder & Urination Issues | ☐ | ☐ Leg Weakness & Cramps |
| | | ☐ | ☐ Cramps & Menstrual Issues | ☐ | ☐ Poor Circulation & Cold Feet |
| | | ☐ | ☐ Cysts & Endometriosis | ☐ | ☐ Knee, Ankle & Foot Pain |
| | | ☐ | ☐ Infertility | ☐ | ☐ Weak Ankles & Arches |
| | | ☐ | ☐ Impotency | ☐ | ☐ Lower Back Pain |
| | | ☐ | ☐ Hemorrhoids | ☐ | ☐ Gluten & Casein Intolerance |

Patient Name: _____ Date: ___/___/___

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CHIROPRACTIC

# Doctor-Patient Relationship in Chiropractic
# Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if you do not understand.

## CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic healthcare services.

## ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When such VSCs are found, chiropractic adjustments and ancillary procedures may be given in order to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of your body.

## DIAGNOSIS

Although Doctors of Chiropractic are experts in chiropractic diagnosis of the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, and will gladly refer you to the appropriate medical specialist; however you are responsible for the final decision.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. The doctor will make every reasonable effort during their examination to screen for such contraindications; however it is the responsibility of the patient to make it known or to learn through health care procedures whether he/she is suffering from latent pathological defects, illnesses, or deformities that would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

## RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory, response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The science of Chiropractic and Medicine may never be so exact as to provide definitive answers to all problems. Among other things, Chiropractic care may reduce pain, increase mobility and improve quality of life.

CERTIFICATION

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may note accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if not care is received. I acknowledge that not guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR NATE BLUME AND/OR DR STACI BLUME TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____

Patient Signature Date

_____

Witness Signature

## Consent of Treatment of Minor Child

I, _____ hereby authorize Drs. Blume and whomever they may designate as their assistant to administer chiropractic care as deemed necessary to my minor child or dependent. In addition, by signing below, I give my permission for the above-named patient to be managed by the doctor even when I am not present to observe such care.

Patient Name: _____ Age: _____ DOB: _____

Authorized Signatory: _____ Relationship to Patient: _____

Signature: _____ Date:_____

## Signature On File

- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original.

Name (please print)

_____

Signature: _____ Date:_____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Cell Phone: _____ Alternate Phone:_____