DEEP ROOTS CHIROPRACTIC

PEDIATRIC FORM

Ages: Newborn-11 years

Today's Date: _____

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Mother's Name: _____ Birthdate: _____-_____-_____ Phone: _____

Father's Name: _____ Birthdate: _____-_____-_____ Phone: _____

Email(s): _____

Siblings + Ages: _____

_____

Pediatrician/Family MD: _____ Last Visit Date: _____-_____-_____

Reason for MD Visit: _____

Who is financially responsible for services received? _____

Weight: _____ Height: _____ Who may we thank for referring you? _____

Purpose of this Visit: ☐ Wellness ☐ Injury or Accident ☐ Other: _____

List The Health Concerns That Brought You into This Office

Primary: _____ Is this condition constant or intermittent? _____

Second: _____ Is this condition constant or intermittent? _____

Third: _____ Is this condition constant or intermittent? _____

Fourth: _____ Is this condition constant or intermittent? _____

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □Other_____

Who? _____ When? _____ Results? _____

Please Mark "**P**" For in The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Migraines
___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems	___Diabetes
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___Seizures	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___Scoliosis	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ Growing pains
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other: _____

PREGNANCY INFORMATION:

How was your pregnancy?

_____

Any pregnancy complications?

_____

Did you take any medication during your pregnancy?

_____

Other information:

_____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle All That Apply) Forceps Vacuum Extraction C-Section

Induced? Y / N Explain:_____

_____

Medications during delivery? _____

_____

Other information:_____

_____

Post Birth Information:

Birth Weight: _____ Birth Length: _____

Breast Fed: Y / N How long? _____ Formula Fed Y / N How Long? _____

Introduced Solid Foods at _____ Months

Food Allergies or intolerances: _____
_____

Any current prescriptions/antibiotics/over the counter drugs? If yes, please list: _____
_____
_____

List all surgical operations & years: _____
_____

Has your child ever been knocked unconscious? □ Yes □ No Fractured a Bone? □ Yes □ No

If yes to either of the above, please describe: _____
_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Back pain Headaches Worst possible pain

0 1 2 3 4 5 (6) 7 8 (9) 10

1. **How would you rate your pain RIGHT NOW?**

_____

0 1 2 3 4 5 6 7 8 9 10

2. **What is your typical or AVERAGE pain?**

_____

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level at its BEST? (How close to 0 does your pain get at its best?)**

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. **What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Office Use Only:

SCORE: #1 ____ + #2 ____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50) (High intensity = >50)

WRITTEN CONSENT FOR A CHILD

I authorize the doctors and any and all Deep Roots Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Deep Roots Chiropractic. I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment. I authorize and request payment of insurance benefits directly to the doctors at Deep Roots Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment. This pertains to any and ALL services rendered.

Acknowledge & Initial Here: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Acknowledge & Initial Here: _____

DEEP ROOTS CHIORPRACITC PHOTO RELEASE

I grant Deep Roots Chiropractic and its employees the right to take photographs of me with connections to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Deep Roots Chiropractic may use such photographs of me and for any lawful purpose, including such purpose as publicity, illustration, advertising, and web content.

Acknowledge & Initial Here: _____

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Deep Roots Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Legal Guardian's Signature: _____ Date: _____

Relationship To Minor/Child: _____

By signing below, I am acknowledging and consenting myself or my minor/child to the above initialed sections (Notice of Privacy Practices Acknowledgement, Informed Consent for Chiropractic Care, & Photo Release)

_____ _____-_____-_____

Parent/Legal Guardian Signature Date Completed

Doctor Use Only

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature _____