WELCOME TO
RESTORATION CHIROPRACTIC

NEW PATIENT FORM (CHILD)

GENERAL INFORMATION - Please print clearly. Information is confidential.

Child's First Name: _____ Last: _____ MI:_____

Date of Birth:____/____/____ Age:_____ Sex: ☐Male ☐Female

Address:_____City:_____ State:_____Zip:_____

Phone (Cell): _____ Phone (Work):_____ Other:_____

Email: _____ Number of Siblings _____

PARENT INFORMATION

☐ Please mark if ***address information*** is same as child's

Parent/Guardian Last Name: _____First:_____ MI:_____

Address:_____City:_____ State:_____Zip:_____

Phone (Home): _____ (Cell): _____ Email: _____

Occupation:_____ Employer's Name:_____

Are you: ☐ Married ☐Single ☐ Widowed ☐ Divorced

SECOND PARENT INFORMATION

☐ Please mark if ***address information*** is same as child's

Parent/Guardian Last Name: _____First:_____ MI:_____

Address:_____City:_____ State:_____Zip:_____

Phone (Home): _____ (Cell): _____ Email: _____

Occupation:_____ Employer's Name:_____

EMERGENCY CONTACT - Please list an individual *other than a parent*

In case of emergency, please notify (First Name):_____ (Last Name): _____

Phone (Home): _____ (Cell): _____ Phone (Work): _____

Address:_____ City:_____ State:_____Zip:_____

Relationship to child:_____

HOW DID YOU HEAR ABOUT US? ☐ Online Search _____ ☐ Referral _____

☐ Event _____ ☐ Social Media _____ ☐Other _____

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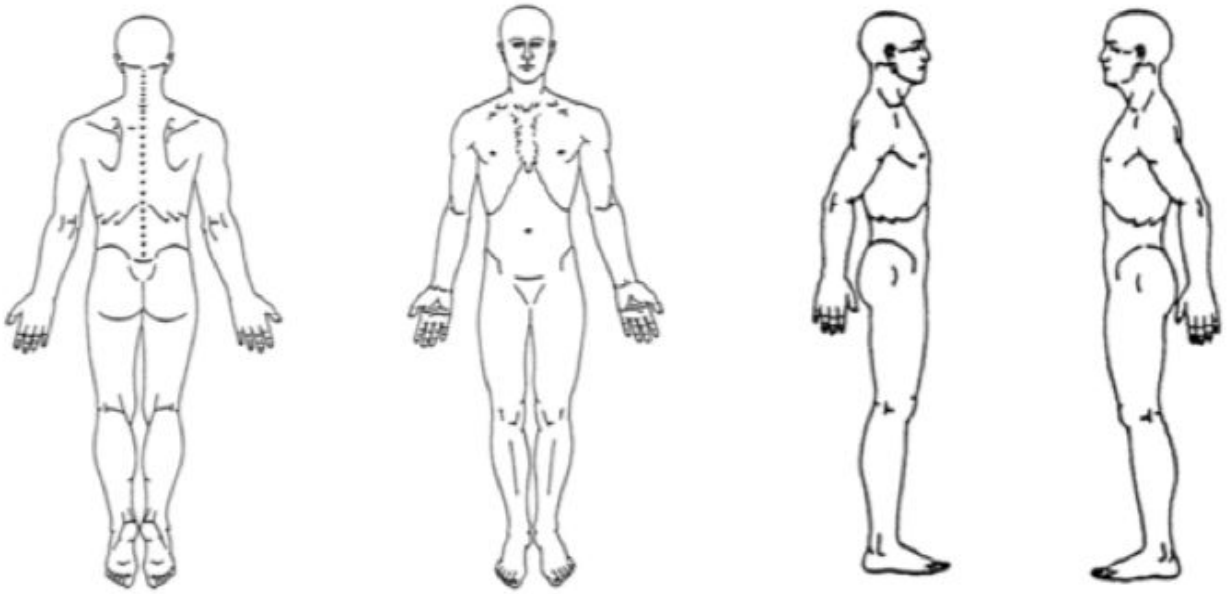
Please <u>circle all areas of complaint</u> for your child on the diagrams below and <u>label them</u> with the following indicators of pain:

A = ache, **D** = dull, **T** = tingling, **N** = numbness, **B** = burning, **S** = sharp or stabbing, **X** = other (please specify)



Please also label the number that best represents the intensity of your child's symptoms in each area of pain on a scale of 0-10 (0 being no symptoms, 10 being extreme)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 EXTREME PAIN

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What is your **PRIMARY COMPLAINT or CONCERN** that brings your child in our office today? _____

_____

Has your child ever had a spinal examination by a Chiropractor? ☐yes ☐no If yes, when?_____

By whom?_____What was the reason for the initial visit?_____

Was your child given any type of treatment plan, home care stretching/strengthening program to assist them in their recovery? ☐yes ☐no If yes, please describe: _____

Did you follow it? ☐yes ☐no If not, why?_____

Why are you changing Chiropractors for your child? _____

CHILD'S HEALTH & INJURY HISTORY

Did the mother/child have any complications during pregnancy or delivery? ☐yes ☐no If yes, please explain: _____

Where did the delivery occur?: ☐Hospital ☐Birthing Center ☐Home ☐Other:_____

Has your child taken antibiotics within the last 12 months? ☐yes ☐no If so, How many times? _____

What other prescription medications has/does your child currently take?_____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc) during their first year of life. Has this happened to your child? ☐yes ☐no

If yes, please explain how/when: _____

_____

Has your child been diagnosed with any disease(s)/health condition(s) by a doctor? ☐yes ☐no

If yes, please explain: _____

_____

Please list all hospitalizations, surgeries, or injuries your child has experienced, and when they occurred:

_____

_____

Is there anything else you would like us to know about your child before we see him/her? _____

_____

_____

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Please check any health complaints your child is currently experiencing or has experienced:

- ☐ Asthma/Allergies
- ☐ Anxiety
- ☐ Constipation
- ☐ Difficulty Breastfeeding
- ☐ Birth Trauma
- ☐ Torticollis
- ☐ Acid Reflux
- ☐ Failure to Thrive
- ☐ Projectile Vomiting
- ☐ Ear Infections
- ☐ ADD/ADHD
- ☐ Growing Pains *(Seivers Disease)*
- ☐ Chronic Colds
- ☐ Missed Developmental Milestones
  - ☐Rolling
  - ☐Crawling
  - ☐Walking
  - ☐Talking
  - ☐Other: _____
- ☐ KISS syndrome
- ☐ Sleep Issues
- ☐ Colic
- ☐ Not reaching
- ☐ Bed Wetting
- ☐ Low Immune function
- ☐ Sports Injury
- ☐ Hip Dysplasia
- ☐ Lack of Focus and/or Concentration
- ☐ Digestive Problems
  - ☐Leaky Gut
  - ☐Chrohn's
  - ☐IBS
  - ☐Other: _____
- ☐ Scoliosis
- ☐ Seizures
- ☐ Car Accident
  Date: _____
- ☐ Fractures *(where?)*:
  _____
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Other _____

ALL PARENTS/GUARDIANS MUST FILL OUT THE PREGNANCY RELEASE BELOW:

☐ _____ **(initial required)** N/A - My child is a male

☐ _____ **(initial required)** N/A - My child has not reached puberty

☐ _____ **(initial required)** N/A - My child is NOT sexually active or on birth control

☐ _____ **(initial required)** N/A - My child **IS** currently pregnant

PREGNANCY RELEASE

This is to certify that to the best of my knowledge my child is not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation and all necessary procedures for care. I have been advised that x-ray can be hazardous to a fetus. Last menstrual cycle _____

Parent 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. It is also important for each patient to understand both the objectives and the methods of chiropractic care. This will prevent any confusion or problems in the future.

Adjustment: An adjustment is the specific application of forces and physiotherapy techniques to facilitate the reduction or correction of spinal misalignment, aka subluxation.
Health: A state of optimal function and not merely the absence of pain, symptoms or disease.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

Our office does not offer to diagnose or treat any diseases or condition other than Vertebral Subluxation. However, if during the course of a chiropractic spinal examination, 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 another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

POLICIES

All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the front desk assistant.

I *(please print)*_____ being the legal parent or guardian of *(child's name)* _____have read and fully understand the above **POLICIES** and **TERMS OF ACCEPTANCE**, and hereby grant permission for my child to receive chiropractic services.

Patient Signature: _____ Date: _____

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AUTHORIZATION AND CONSENT TO EVALUATE AND TREAT A MINOR

I understand that during examination, the doctor may feel that x-rays will be needed in order to diagnosis my child's condition. Restoration Chiropractic would like to make you aware that x-rays may be required, in order, to administer treatment. It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The
x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while your child is a patient in this office.

By signing this form, I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my child's best interest.

By signing below I agree to the above and allow the doctor(s) and staff affiliated with Restoration Chiropractic to perform such treatment on my child. This consent will cover the entire course of my child's treatment.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer x-rays and/or chiropractic care, to work with my child's condition through the use of adjustments and procedures the doctor(s) deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance companies to pay Restoration Chiropractic directly any amounts payable as my assignment of benefits, and authorize the use of this signature on any insurance submissions that may apply.

I *(please print)*_____ being the legal parent or guardian of *(child's name)* _____have read and fully understand the above **AUTHORIZATION AND CONSENT TO EVALUATE AND TREAT A MINOR,** and hereby grant permission for my child to receive chiropractic services.

Patient or Guardian Signature: _____ Date: _____