



Chiropractic is the health care profession that focuses on the proper alignment of the spine, eliminating nervous system interference and allowing true health to be expressed. Welcome to Rochester Family Chiropractic.

HISTORY (0-9 years) PEDIATRIC

Patient Name:
Name of Parents / Guardians:
Address: City:
State: Zip: Birth Date:
Sex: Weight: Height:
Home Phone: Work Phone:
Parental email address:
How did you hear of us?
If referred, whom may we thank?

PURPOSE FOR CONTACTING US?

( ) Spinal well-care/prevention ( ) Other (please explain):
Other doctors seen for this condition? ( ) NO ( ) YES, please list Doctor's names and treatments:

Other health concerns?

CHILD'S HEALTH PROFILE. Please mark "O" for a past condition, "X" for present condition

- Ear Infections ADHD Colic Back Pain
Scoliosis Chronic Colds Asthma/ Allergies Neck Pain
Seizures Headaches Recurring Fevers Muscle/joint Pain
Bed Wetting Digestive Growing Pain Poor posture

Other:

Name of Obstetrician /Widwife: Phone:

Name of Pediatrician: Phone:

Date of last visit: Reason:

Are you satisfied with the care your child has received there? NO / YES

Number of antibiotics doses your child has taken over his/her lifetime:

Past and current medications:

Any nutritional supplements/vitamins?

Please list any major illnesses/surgeries your child has had:

Has your child ever been involved in a car accident?

Has your child ever been seen on an emergency basis?

According to National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.)

Has your child fallen from a height of over three feet? ( ) NO ( ) YES, at what age:

Has your child ever had any other trauma?

Is your child involved in high-impact or contact sports?

**VACCINATION HISTORY:**

( ) Chosen to decline ( ) On schedule ( ) Undecided

Any adverse reactions? \_\_\_\_\_

**FAMILY HEALTH HISTORY**

CHECK HERE IF CHILD IS ADOPTED: \_\_\_\_\_. Indicate using the letters if any of the blood relatives of the patient had the following. Mother(M) Father(F) Siblings(S) Paternal grandmother (PGM) Paternal grandfather(PGF) Maternal grandmother(MGM) Maternal grandfather(MGF)

- |                |                    |                     |                     |
|----------------|--------------------|---------------------|---------------------|
| ____ Asthma    | ____ Hypertension  | ____ Eczema         | ____ Kidney Disease |
| ____ Diabetes  | ____ Ulcers        | ____ Heart Disease  | ____ Stroke         |
| ____ Scoliosis | ____ Cancer        | ____ Mental Illness | ____ Other          |
| ____ Allergies | ____ Liver disease | ____ Hypoglycemia   |                     |

**PRENATAL HISTORY:**

Complications during pregnancy? NO / YES List \_\_\_\_\_

Medications during pregnancy? NO / YES List \_\_\_\_\_

Cigarette/ Alcohol/ Drug use during pregnancy? NO / YES List \_\_\_\_\_

Location of Birth: ( ) Birthing Center ( ) Home ( ) Hospital

**BIRTH HISTORY:**

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_, \_\_\_\_\_

Premature delivery? ( ) NO ( ) YES, list at what week: \_\_\_\_\_

Breech Presentation? ( ) NO ( ) YES; Breech \_\_\_\_\_, Transverse/Side \_\_\_\_\_, Face/Brow \_\_\_\_\_

Birth intervention? ( ) Forceps ( ) Vacuum Extraction ( ) Pulling

Cesarean section? ( ) Emergency ( ) Planned

Complications during delivery? ( ) NO ( ) YES, list: \_\_\_\_\_

Medications during delivery? ( ) NO ( ) YES List: \_\_\_\_\_

Genetic Disorders or Disabilities: ( ) NO ( ) YES List: \_\_\_\_\_

**FEEDING HISTORY:**

Breast fed: ( ) NO ( ) YES, list for how long: \_\_\_\_\_

Formula fed ( ) NO ( ) YES, list for how long: \_\_\_\_\_

Difficulty breastfeeding? \_\_\_\_\_ Introduced to solids at: \_\_\_\_\_ months

Food allergies or intolerances: \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

During the following times your child's spine is vulnerable to stress and greatly benefits from routine spinal checks for the prevention and detection of vertebral subluxation (spinal nerve interference). Place an X if your child has/had difficulty during the following stages.

- |                       |                  |                 |
|-----------------------|------------------|-----------------|
| ____ Respond to sound | ____ Crawl       | ____ Walk Alone |
| ____ Hold head up     | ____ Sit alone   | ____ Talking    |
| ____ Roll over        | ____ Stand alone |                 |

**CHILDHOOD DISEASES:**

Place an X if your child has had any of the following childhood diseases.

Chicken pox\_\_\_\_\_ Mumps\_\_\_\_\_ Rubella \_\_\_\_\_ Measles \_\_\_\_\_ Whooping Cough\_\_\_\_\_

**LIFESTYLE QUESTIONS**

- How often does your child consume juice? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- How often does your child consume milk? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- How often does your child consume soda? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- Does your child eat balanced, healthy meals? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- Does your child consume artificial sweeteners ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- Does your child eat fast foods/prepared food? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- Is your child exposed to smoke? ( )rarely ( )1-2x/day ( )2-3x/day ( )more
- Is your child's backpack more than 10% of their body weight? ( )NO ( )YES, aprox. wt\_\_\_\_\_
- How many hours a day does your child watch TV/computer/video games? \_\_\_\_\_
- How many hours a day does your child play/engage in sports? \_\_\_\_\_
- Is your child uncomfortable in social settings? ( )NO ( )YES \_\_\_\_\_
- Average hours of sleep your child gets per night?\_\_\_\_\_ Naps? ( )NO ( )YES

**WE ARE HERE TO SERVE YOU AND YOUR FAMILY.  
 WE ENCOURAGE YOU TO ASK QUESTIONS.  
 YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR FAMILY'S RESULTS.**

**AUTHORIZATION AND CARE OF MINOR**

I hereby authorize Dr. Laura Nicholson to administer chiropractic care to my Son/Daughter.

Child's Name: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's printed name: \_\_\_\_\_

**CONSENT TO CHIROPRACTIC CARE**

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Laura Nicholson, D.C. and/or any other chiropractic personnel who may be involved in the course of my treatment. Procedures may include the following: patient history, patient exam with orthopedic, neurological and chiropractic assessment, diagnostic x-rays, report of findings, chiropractic adjustments, heat and cold therapy, therapeutic massage and reassessment exams. I understand that Dr. Nicholson and/or personnel will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that with all health care delivery systems, including medicine, the practice of chiropractic may have potential complications. Possible risks may include post-treatment soreness, disc injury aggravation, joint, ligament, tendon or soft tissue injury and osseous tissue injury. As for a risk of stroke, according to the journal, *Spine* 2008; 33 (4S):S176-S183, patients are no more likely to suffer a stroke following a visit to a chiropractor than they would after stepping into their family doctor's office. The potential incidence is so rare that it is considered statistically insignificant. Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms.

I understand that chiropractic care involves the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me. I wish to rely on Dr. Nicholson to exercise judgment during the course of the procedure which she feels at the time, based upon the facts then known, is in my best interests. I have had an opportunity to discuss to my satisfaction with Dr. Nicholson, or other clinic personnel the nature and purpose of chiropractic adjustments and therapy procedures. By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents.

Printed Parent/Guardian Name

Signature

Date

**AUTHORIZATION OF PAYMENT**

I authorize and request my insurance carrier to pay directly to Rochester Family Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my child's behalf.

Printed Parent/Guardian Name

Signature

Date

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that Rochester Family Chiropractic "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Rochester Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of use and disclosures of my protected health information that will occur in my care, payment of my bills and/or in the performance of health care operations of Rochester Family Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practice for Rochester Family Chiropractic is available at the main administrative desk of this practice. Rochester Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy.

Printed Parent/Guardian Name

Signature

Date

Office Personnel/Witness