Thrive Family Chiropractic
Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients! Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ **Today's Date**: _____**Birth Date:** ___/___/___

Sex: M / F **Weight**: _____lbs. . **Height**: _____ft._____in. **Phone #**_____

Address: _____**City**:_____

State: _____ **Zip**: _____ **Parent/ Guardian:** _____

Referred by: _____

Reason for pursuing care: □maintenance □improved health □problem: _____

Family history:

_____

Check any of the following conditions that currently apply:

____ Ear infections ____ Scoliosis ____ Chronic Colds ____ Headaches ____ Allergies

____ Digestive problems ____ADHD/ADD ____ Recurring Fevers ____ Colic ____Growing/ back pains ____ Bed wetting ____Temper Tantrums ____ Seizures ____Asthma ____Car accident (When)

Other 1: _____

Other 2: _____

Other doctors seen for this condition (Please include doctor's names and prior treatment):

_____

Previous Chiropractic Care? Y/ N Last visit: ___/___/___
Name of Pediatrician: _____ **Last visit:** ___/___/___
Are you satisfied with the care your child has received at the pediatrician? Y/N
# of Doses of antibiotics your child has taken: Past 6 months _____ Total lifetime _____
Present prescription drugs/ dosage? _____
Past prescription drugs/ dosage?
_____
Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)_____

Prenatal History (Circle what applies)

Name of Obstetrician/Midwife: _____

Complications during pregnancy/delivery? Y/N Explain: _____

Ultrasounds during pregnancy? Y/N How many? _____

Medications taken during pregnancy/ delivery? Y/N List: _____

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it (circle one): Emergency Planned

Genetic disorders/disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____APGAR Scores: _____-_____

Feeding History

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

Introduced to: Solid Foods @_____ months Cow's milk @ _____ months

Food/ Juice allergies or intolerances: Y/ N List: _____ ____

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

_____ Sit up

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. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? Y/N Explain:

_____

Other traumas not described above (bike wipeout, trampoline injury, etc.)?

_____

Has your child been involved in any sports? Y/N List:

_____

Has your child been seen by a physician on an emergency basis? Y/N Explain:

_____

Lifestyle (please check all that apply):

Does your child: □eat healthy food (organic products, etc.) □drink water

□take probiotics □take vitamins Type: _____

Exercise: □none □mild □moderate □heavy □daily

Hobbies/ interests: _____

_____

Is there anything else you would like us to know about your child?

_____

Parent/ Guardian name: _____ Signature: _____

(Optional) We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Thrive Family Chiropractic, PLLC, or anyone authorized by Thrive Family Chiropractic, PLLC., of any and all photographs/videos which were taken of my child, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Thrive Family Chiropractic, PLLC., solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Thrive Family Chiropractic, PLLC to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

I understand that I am directly and fully responsible to Shane Hoffman, D.C. for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

CONSENT TO TREAT A MINOR

Patient Name: _____ Date of Birth: _____

*Note: if you have more than one child, you may request a form in the office to include all your children

I,_____, parent or legal guardian of the above named child(ren), give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child(ren) including, but not limited to, diagnostic assessments, x-rays, medical records, billing, and chiropractic adjustments. I also authorize the discussion of confidential information regarding my child(ren) with the below authorized caregiver.

Authorized Caregivers:

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

_____ (Practice Member Initials) *I understand that any person binging my child(ren) in for treatment not listed above must have a letter of consent from me or treatment may be delayed or refused. This authorization will remain in effect until information for consent is provided or otherwise denied. If any person on the above list changes, it is my responsibility to contact Thrive Family Chiropractic, PLLC. and sign an updated consent form.*

Parent/Guardian Signature: _____ Date: _____

Thrive Family Chiropractic Representative: _____ Date: _____

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 THE X-RAYS IN OUR FILES.

PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF THRIVE FAMILY CHIROPRACTIC, PLLC. DO 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.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME _____ CHILDS AGE _____

PARENT/GARDIAN SIGNATURE_____ DATE _____