Welcome to Village Chiropractic

Consent to Treat a Minor

Child's Name: _____

Parent's Name: _____

_____

Parent Consent/Signature

Address: _____

City: _____State/Zip: _____

Birth date: ___/___/____ SSN: _____

Occupation: _____

Circle One: Female / Male

Whom may we thank for referring you? _____

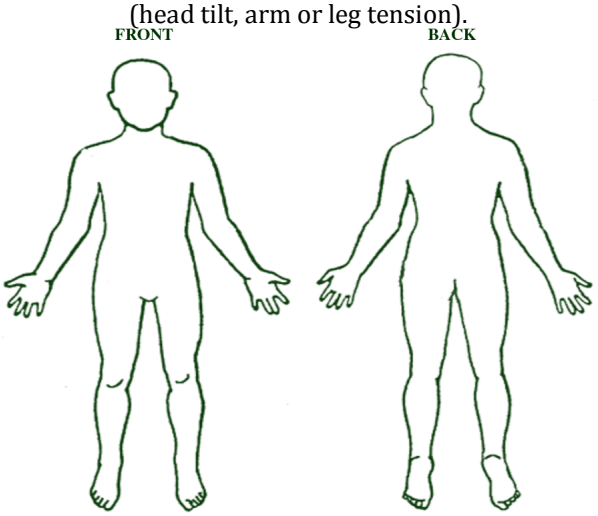
Child's Condition

Reason for visiting: _____

Behavioral Changes?: _____

Is this condition getting progressively worse?_____

Mark an **X** on the picture where the child has pain, redness or rash. Mark any postural signs of stress (head tilt, arm or leg tension).



Type of pain: ____ Sharp ____Dull ____Burning ____Constipation ____Colic ____Shooting ____Tingling ____Cramps ____Stiffness ____Swelling ____Rash ____Redness ____Other:_____

How often do you have this pain?: _____

Is it consistent or does it come and go?:_____

Does it Interfere with: ____School ____Recreation ____Sleep ____Daily Routine ____Other: _____

Activities that are painful to perform:

____Sitting ____Standing ____Walking ____Bending

Anything else we should know?:_____

_____

Parent's Phone Numbers

Cell Phone: (_____) _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Parents Email: _____

Emergency Contact: _____

Emergency Contact #: (_____) _____

Family History

Please check any that apply to your family:

____Cancer ____Seizure ____Kidney Disease ____Diabetes ____Heart Disease ____High blood pressure ____Ulcers ____Osteoarthritis ____Alcoholism ____Arthritis ____Other

Insurance Information

Who is responsible for this account?: _____

Relationship to patient: _____

Insurance Company: _____

Policy # _____

Assignment and Release

I certify that I have healthcare insurance and assign directly to Village Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent or Guardian

_____

Please Print Name of Patient, Parent or Guardian

____/____/____ _____

Date Relationship to patient

Accident Information

Is this condition due to an accident? _____

Date of the accident: _____

Type of Accident :

____Auto ____Home ____ Other

Who have you reported this accident to?:

___Auto Ins. ___M.D. ____School

HEALTH HISTORY

Prenatal/ Neonatal

Describe your pregnancy: 1st, 2nd, 3rd trimester details: _____
Illness/Problems during pregnancy: _____
Labor/ Delivery (vaginal, c-section, forceps, vacuum, complication): _____
Hours in labor: _____ Hours Pushing: _____
Delivery Location: _____ Care Provider: _____
Drugs used during pregnancy/ Labor: _____
APGAR Score: _____
Neonatal health issues (jaundice, respiratory problems, infections, digestion): _____
_____

Nutrition Information

Breast Fed: _____ Bottle Fed: _____ Other: _____
Feeding Schedule: _____
Intro to solid foods: Age _____ Foods _____
Food Allergies: _____
Favorite Foods: _____
Feeding problems (regurgitation, colic): _____
_____
Appetite & Attitude during meals: _____
Use of supplements: _____

Medical Survey

Immunizations & Ages: _____
_____
_____
Reactions to Immunizations?: _____
Childhood Diseases: _____
Number of Ear Infections: _____
Allergies/ Sensitivities: _____
Injuries/Fractures/ Hospitalizations: _____
_____

Family Information

Mother - Age: _____ Health Status: _____
Father - Age: _____ Health Status: _____
Siblings - Ages _____ Health Status: _____
Family Dynamics (who is in the household?):
_____
Bedtime: _____ Wake-up Time: _____
Daily Schedule (school/daycare, activities, meals):
_____
_____

Growth and Development

Birth Weight: _____ Birth Length: _____
Age at: Head Control ____, Smile____, Crawl ____,
Sitting ____, Standing____, First Words____
Sleep Patterns: _____
Toilet Training (bedwetting) _____
Other Habits (thumb sucking, rocking) _____
_____
Discipline (tantrums, withdrawl, listening): _____
_____
Socialization (school/ daycare, activities): _____
_____

Trauma: Please describe any that apply to your child

Falls _____ Date ____/____/____
Head Injuries _____ Date ____/____/____
Broken Bones _____ Date ____/____/____
Dislocations _____ Date ____/____/____

Medications

Drug Name	Condition Being Treated

Daily Foods

_____
_____
_____
_____
_____

Vitamins

_____
_____
_____
_____
_____