PEDIATRIC HEALTH HISTORY (Teenager)

Child's Name_____ DOB:_____ Age:___ □ Male □ Female

Address _____City_____State_____Zip_____

Height_____ Weight_____ Grade_____ # of Siblings_____ Ages_____

Mother_____Cell#_____Father_____Cell#_____

Home Phone _____Mothers / Fathers Email_____

Pediatrician/Family MD _____ Office Location: _____

Who is responsible for this account? □ Mother SS#_____-_____-_____ □ Father SS#_____-_____-_____

Whom may we thank for referring you?_____ □ Phone Book □ Website □ Sign □ Other_____

Welcome to our office. We are honored that you have chosen our office to serve your family. Please know that we will care for your child with the greatest respect and treat them as if they are our own.

Why did you decided to have your child evaluated at our office?

- He/She is continuing ongoing care from another chiropractor.
- I recently had my spine and nervous system checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He/She has a specific condition and I've learned that chiropractic may be able to help.
- I'm interested in improving my child's overall health and wellness.
- Other:_____

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve for this child. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Enhanced Emotional Well-Being	Better Concentration
Stronger Immune System	Other_____	

Current Concern (if any): *(circle, highlight or write where applicable)*

- Check here if your child is here for a wellness check-up and skip to the next section (Pregnancy & Birth History)

Primary Concern_____

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM Bed It Varies It's getting: Better Worse No Change

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____

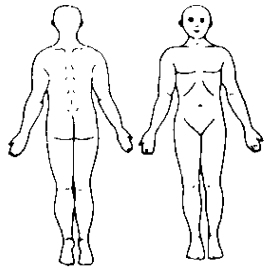
h. Has your child seen anyone for this? Yes No Who?_____

i. What were the results of the treatment?_____

j. Any medications taken for this problem?_____

k. How does this affect their life? *(circle/write)* poor school performance / irritability / interrupted sleep / fatigued / restricted daily activities / hinders social activities / other_____

Mark areas below



Other Concerns *(briefly describe)*_____

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Health History: *(circle, highlight or write where applicable any **past or present** health challenges)*

Asthma	Sinus Problems	Allergies_____	
Frequent Colds	Ear Infections / Tubes	Headaches/Migraines	Seizures
Fainting	Dizziness	Behavioral Problems	ADD/ADHD
Neck Pain	Arm Pain	Back Pain	Leg Pain
Scoliosis	Poor Posture	Muscle Pain	Growing Pains
Colic	Constipation	Diarrhea	Digestive Disorder
Reflux	Stomach Aches	Bladder Problems	Bed Wetting
Poor Appetite	Anemia	SI Problems_____	
Heart Condition	Night Terrors	Learning Disorders_____	
Sleeping Trouble	Tantrums	ASD (type)_____	

1) List any allergies: No known / _____
2) Vitamins/Herbs/Minerals/etc: None / _____
3) Current medications: None / _____
4) Does your child follow a special diet: Yes No _____
5) Does your child consume: *(circle)* Caffeine Processed Foods Artificial Sweeteners Soda
   Fast Food Fresh Fruits Fresh Vegetables Sugar
6) Please list any sports your child plays:_____
7) How many hrs/day does your child spend: watching tv?_____ Playing computer/video games?_____
8) Please rate the following for your child: (P) Poor, (G) Good or (E) Excellent

   Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Spinal Health: *(circle, highlight or write where applicable)*

1) Has your child ever had their vision checked by an optometrist before? Yes No
2) Has your child ever had their spine and nervous system checked by a doctor of chiropractic before? Yes No

   Who?_____Date of last visit?_____Reason for ending care?_____
3) Have they ever had spinal x-rays taken? Yes No When?_____ Were they standing? Yes No
4) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.

   Does your child ever feel the need to twist, stretch or crack their neck or spine? Yes No
5) Poor posture leads to poor health and often indicates spinal problems. Please rate your child's posture?

   Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
6) Stress can cause or accelerate spinal damage. Rate your child's stress level for the last 90 days.

   Low - 1 2 3 4 5 6 7 8 9 10 - High

Injuries/Surgeries: *(Date & Description)*

Auto Accidents: N/A / _____

Recreational Accidents: N/A / _____

Fractures / Dislocations: N/A / _____

Surgeries: N/A / _____

Family History:

Does anyone in your family suffer with any of the following conditions? *(Please circle or highlight Father &/or Mother)*

F M Heart Disease	F M Strokes	F M Cancer (types):_____
F M High BP	F M Thyroid	F M Neurological - Parkinson's, ALS, MS, other_____
F M Diabetes	F M Asthma	F M Other_____

Continued on next page...

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of?_____

Fees & Care Plans:

Initial Exam	$95 - $125
X-rays	$75/set (typically 2 sets with initial start up)
Adjustments	$45 - $60
Re-Exam	$60

On your second visit, Dr. Sullivan will review the results of your child's exam and go over their care plan. We will also review the financial responsibilities regarding care. If you have insurance, please read the section below.

Insurance: We used to be 'in network' with many insurance companies however we found being 'out of network' offered most of our patients' *better* coverage and *fewer* restrictions. We can work with most insurance companies to submit claims electronically on your behalf. Currently we are ***'in network'*** with **Medicare** and are considered ***'out of network'*** for **all others**. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit.

MEDICAID – Medicaid **DOES NOT** offer ANY chiropractic benefits. Fees listed above will be your financial responsibility.

Consent to evaluate and treat a minor:

I, _____ being the parent or legal guardian of _____ have filled out the above information to be accurate to the best of my knowledge. After careful consideration I do hereby request and authorize a complete evaluation including 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.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care my child receives whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years.

The above information is true and accurate to the best of my knowledge.

_____	_____	_____	_____
Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date	Dr. Initials

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____ _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

_____	_____	_____
Patient Signature	Date	Dr. Initials

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ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Patient Signature:_____ Date:_____ Score:_____

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BC FAMILY CHIROPRACTIC, PC
365 HARRY L. DRIVE
JOHNSON CITY, NY 13790
(607) 754-5900 / (607) 217-5257 (fax)

Informed Consent

We encourage and support a **shared decision making process** regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation. A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and/or radiological examination (x-rays).

The **chiropractic adjustment** is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some **risks and limitations** of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BC FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**

PARENTAL CONSENT FOR MINOR PATIENT:

Patient Name: _____ age: ____ DOB: _____ Relationship to patient_____

_____ _____	_____	_____
Parent / Legal Guardian Name	**Parent / Guardian Signature**	**Date**

CONSENT TO TREAT WITHOUT A PARENT / GUARDIAN PRESENT:

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

_____	_____	_____
Parent / Legal Guardian Name	**Parent / Guardian Signature**	**Date**