Pediatric Registration 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: _____ Date: _____

Address: _____ City:_____

State: _____ Zip: _____ Phone #_____ Parent's Email: _____

Birth Date: _____/_____/_____ Male/Female (Circle one) **Weight**: _____lbs. **Height**: _____ft._____in

Parent/Guardian: _____ Referred by: _____

Reason for pursuing care: ☐Health Maintenance ☐Improved Health ☐ Problem: _____

Previous Chiropractic Care? Yes / No Last visit: _____/_____/ _____

Name of Pediatrician: _____ Date of last visit: _____/_____/_____

Are you satisfied with the care your child has received at the pediatrician? Yes / No

Health Concerns:

Health Concerns: List in order of importance	**Severity:** **1**=Mild **10**=Unbearable	**Duration:** How long has your child had this?	**History:** Has your child had this before?	**Frequency:** Is it constant or comes/goes?
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____

Notes:

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

_____

Family history: _____

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Please check off any of the conditions below that your child, you (or your family) have or have experienced in the past: **- Write C if current issue or P if past issue**

	Child	Mother	Father	Siblings
Allergies				
ADHD/ADD				
Bedwetting				
Asthma				
Car Accident				
Chronic Colds				
Colic				
Digestive Problems				
Ear Infections				
Growing/Back Pains				
Headaches				
Nervousness				
Scoliosis				
Seizures				
Recurring Fevers				
Stomach Aches				
Temper Tantrums				

Medication History:

Number of doses of antibiotics your child has taken:

Past 6 months: _____ Total lifetime: _____

Reflux Medications (i.e. PPI or Histamine-Blocking Drugs)

Yes / No Name of Medication: _____

Present prescription drugs/dosage? _____

Past prescription drugs dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)_____

Prenatal/Birth History: (Circle what applies)

Name of Obstetrician/Midwife: _____

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

Complications during pregnancy/delivery? Yes/No Explain: _____

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section None

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

Ultrasounds during pregnancy? Yes / No How many? _____

Medications taken during pregnancy/ delivery? Yes/No List: _____

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

Feeding History

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Breast Fed: Yes/No How long? _____ Formula Fed: Yes/No How long? _____ Type: _____

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

Food/ Juice allergies or intolerances: Yes/ No List: _____

Has your child experienced skin reactions to certain foods? Yes / No List: _____

Does your child: ☐Eat healthy food (organic products, etc.) ☐Drink water ☐Take probiotics ☐Take vitamins

Details: _____

Developmental History (To the best of your knowledge!)

Your child's nervous system 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? Yes/No

Explain: _____

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

_____

Has your child been involved in any sports? Yes/No List: _____

_____

_____

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

_____

Do you feel that your child is developing at a level consistent with your expectation, or compared to their peers? _____

_____

Lifestyle:

Exercise: ☐None ☐Mild ☐Moderate ☐Heavy ☐Daily

Hobbies/ Interests: _____

_____

Child's Name _____ **Date:** _____

Parent/ Guardian Name: _____ **Signature:** _____

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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 doctor at Legacy Family Chiropractic does 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 ten, it is unlikely they will need chiropractic postural X-rays. 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 _____

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE

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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: _____

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 Legacy Family Chiropractic and sign an updated consent form.*

Parent/Guardian Signature: _____ Date: _____

Higher Health Representative: _____ Date: _____

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(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 Legacy Family Chiropractic or anyone authorized by Legacy Family Chiropractic 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 Legacy Family Chiropractic 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 Legacy Family Chiropractic 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: _____