genesis
FAMILY CHIROPRACTIC
Where true health begins.

Pediatric Health Record

ABOUT YOUR CHILD

Child's Name: | Date of Birth:

Parent/Legal Guardian Name:

Address:

City: | State/Zip: | Email Address:

Primary Phone: | Secondary Phone:

Marital Status: | Single | Married | Separated | Divorced | Widowed

Spouse's Name: | Anniversary:

Children (Names & Ages):

How did you learn of our office?

Has any member of your family ever seen a chiropractor? Y N

If yes, please tell us about your/their experience:

REASON FOR THIS VISIT

What brings you in today?
Wellness Condition
If condition, please describe:

What are your major health concerns for your child? When did you first notice these issues?

Concern	Date
_____	_____
_____	_____
_____	_____
_____	_____

Over time, has/have the issues/concerns:
Gotten worse Stayed constant Come and gone

How has this issue affected your child's life? Please explain.

Please list any traumas, major injuries, surgeries or hospital stays with approximate dates.

Have your child been in a motor vehicle accident? yes no
If so, please describe the incident including the date(s).

Does your child participated in any high impact/contact type sports (e.g., soccer, football, martial arts, etc.)?
yes no
Please explain:

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CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please circle each of the diseases or conditions that you have ever experienced. While they may seem unrelated to the purpose of this appointment, they can affect the overall assessment, care plan and possibility of being accepted for care.*

Abnormal blood sugar	Acid reflux	Allergies/sinus problems	Anxiety	Asthma
Back pain/stiffness	Difficult weight gain	Blood pressure (high or low)	Ear Infections	Cholesterol (high or low)
Cold feet	Cold hands	Cold sweats	Constipation or diarrhea	Depression
ADD/ADHD	Dizziness or loss of balance	Fainting	Fatigue	Fever
Frequent colds, coughs, etc.	Headaches	Heartburn	Hip/knee/ankle pain	Mood swings
Neck pain/stiffness	Irritability	Lights bother eyes	Loss of smell or taste	Ringing in ears
Shoulder/elbow/wrist pain	Nervousness	Numbness/tingling in arms/hands	Numbness/tingling in legs/feet	Upset stomach
Urinary tract infection	Sleeping problems	Stress or tension	Ulcers	Lacking motivation
Poor concentration	Impulsiveness	Easily distracted	Disorganized	Worry
Teeth grinding	Spaciness	Low pain threshold	DIfficulty waking up	Poor immune system
Racing mind	Heart palpitations	Restless sleep	Poor expression of emotions	Bipolar disorder
Panic attacks	Sleepwalking	Food sensitivities	Eating disorders	Bed wetting
Colic	Migraines	Vertigo	Seizures	Learning Challenges

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (i.e., bed, changing table, stairs, etc.).
Was this the case for your child? Y N
If yes, please explain:

Does your child have difficulty interacting with others? Y N
If yes, please explain:

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? Y N
If yes, please explain:

MEDICATIONS/VACCINATIONS

Number of doses of prescription or over-the-counter medication(s) your child has taken during his/her lifetime:

Please list any supplements or prescriptions you are currently taking, the dosages of each, and how long you have been taking them. (If you need more space, please write on the back of this page.)

Supplement/Prescription	Dosage	How long taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Have you chosen to vaccinate your child? Y N

If yes, circle all that your child has received:

DPT MMR Chicken Pox Hepatitis Other

Please describe any and all reactions to vaccine(s):

CHEMICAL (NUTRITIONAL) HEALTH HISTORY

Describe your child's typical meal for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Approxiately how much water does your child drink daily? _____

Does your child drink soda? Y No

How much per day? _____ Per week? _____

Please describe your child's bowel movements and urine:

	Bowels	Urine
Frequency	_____	_____
Color	_____	_____
Consistency	_____	

PRENATAL HISTORY

During pregnancy did you use: drugs/medications tobacco/alcohol

If yes, please list:

Location of birth (please circle): home birthing center hospital

Describe your delivery:

_____ Labor was chemically induced

_____ Labor was doctor assisted

_____ C-Section Delivery

_____ Forceps/Vacuum extraction

_____ Doctor pulled or twisted baby

_____ Premature delivery

Please Explain:

Describe any complications experienced during delivery:

Did you exerience any illnesses while pregnant? Y N

Please explain:

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Please describe any genetic abnomalies or disabilities:

Birth Weight:

Birth Length:

Apgar Scores:

Ultrasound during pregnancy: Y N Number: _____

Did you breastfeed the baby? Y N If yes, how long? _____

Did you formula feed the baby? Y N If yes, how long? _____

At what age did you introduce:

Solids: _____

Cow's Milk: _____

Are you aware of any food or juice allergies or intolerance? Y N
If yes, please describe:

LIFESTYLE HEALTH HISTORY

Does your child exercise daily? Y N
If yes, how much?

How much screen time does your child get each day? _____

INSTRUCTIONS: *On the diagram in the column to theright, place an* ***X*** *where you believe your child's health is right now and a* ✓ *where you would like his/her health to be.*

How long do you think it will take to get to where you circled in the diagram on the right?

_____

What might you need to change to help your child reach his/her goal?

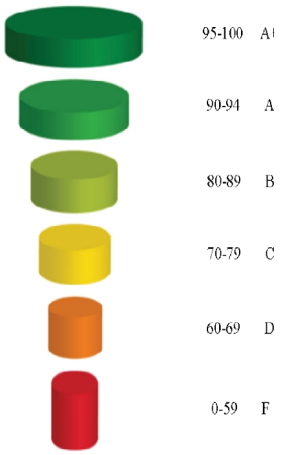
_____

_____

_____

_____

_____



FOR FEMALES ONLY
Has your daughter had her first cycle? Y N Pain during: cycle ovulation

When was her first menses? _____

To the best of my knowledge, at present, my daughter is not pregnant and I hereby release Genesis Family Chiropractic and radiological staff from any responsibility or liability upon my being x-rayed for the purpose of diagnostic evaluation.

_____ _____
Patient signature Date

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GOALS AND EXPECTATIONS

If you could improve one thing about your child's health, what would it be?

If we could make recommedations that would not only address your main concerns, but could also help you with improving your child's overall health, would you like to hear them? Y N

STAGES OF CARE

There are three stages of chiropractic care. Please initial in the space beside the type of care you are seeking for your child.

_____	Relief care (eliminate my symptoms only)
_____	Corrective care (eliminate the underlying issue in hope of correction, and reduce the likelihood of reoccurrence)
_____	Wellness care (optimize the function of my body's systems in order to live a more vibrant life)
_____	Let the doctor choose the level of care that is most appropriate for me.

Patient Policies

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorizationis strictly limited to defined situations that include emergency care, quality assurance activities, public health, research,andlaw enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to review changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privace regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as qulity assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Please print):	Relationship to Patient:
Signature:	Date:

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the spine. This can cause alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:	Date:

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Appointment Policy

Appointments with Genesis Family Chiropractic are scheduled according to the program of care that the doctor feels is best for you. This customized program will consist of three stages: relief care (relief from pain), corrective care (maintaining stability), and wellness care (prevention). Depending on where you begin, multiple adjustments will be scheduled for you in a concentrated amount of time, followed by re-evaluations to monitor your progress. As you improve and your health stabilizes, you will be promoted into the next stage of care.

After completion of the initial program, a consultation will be scheduled to re-evaluate your stage of care and to outline a new, customized program including health goals, accountability, and wellness education.

If you are unable to keep an appointment, we require that you inform us with 48-hours notice. Genesis Family Chiropractic reserves the right to charge $50.00 for missed appointments or for those appointments cancelled without a 48-hour notice. **In order to achieve your best results, every cancelled appointment must be made up.**

Following the schedule that your doctor outlines for you is of paramount importance. We ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results.

When entering the office on any given visit, please stop by the front desk to check-in. Once you have checked in, you may then proceed to any open adjusting table (if available) or one of the "hot-seats" in anticipation of the next available table. We strive to honor all appointments at the scheduled time. If you are late, or expect to be late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office, policies or your appointments please do not hesitate to ask.

Signature:	Date:

Consent for Chiropractic Examination

I hereby give my consent to a professional and complete chiropractic examination and to any x-ray examination that the doctor deems necessary. I understand and agree that payments to this office for x-rays are for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid-in-full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition using adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

Signature:	Date:

Office Use Only

Thank you for making me so wonderfully complex! Your workmanship is marvelous—how well I know it. Psalms 139:14