Global Health Chiropractic

We are honored that you have chosen us to assist you and your family's health & wellness needs. Please let us know if there is any way we can make you and your family more comfortable. We look forward to working with you to build better health for your family.

Pediatric History & Adolescent Form (birth to 16 years)

Patient Name: _____ Nick-Name _____ Date _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/_____ Sex: _____ Weight: _____ Height: _____
Whom may we thank for referring you to our office?
_____
Father's Name: _____ Mother's Name: _____
Father's Cell Phone: _____ Mother's Cell Phone: _____
Home Phone: _____ Email: _____

Parent's marital status (please circle): Single Married Divorced Widowed
In the event we need to contact you, what is the best method of communication for your family?

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or the other members of your family:
Yourself/Spouse:_____
Other Children:_____
Others:_____

Purpose for Contacting Us (please circle any of the following):
Spinal Check-Up Wellness Other
Please Explain:_____
If Applicable: Other Doctors Seen for This Condition: ____No ____ Yes
Doctor's Name & Prior Treatments:
_____
Previous Chiropractor:
_____
Date of Last Visit: ___/___/_____
Reason:_____
Name of Pediatrician: _____ Date of Last Visit: ___/___/_____
Reason: _____

Your Child's Health Profile:

Vaccination History:

(Please check) __Up to Date __ Chose to decline Vaccinations __Still Deciding

Please describe any adverse reactions to vaccinations:

_____

I would like more information on the adverse reactions and potential dangers of vaccinations

__yes __no

Please mark an "O" if it is a *Past Condition* or an "X" for a *Present Condition*.

__ Ear Infection __Scoliosis __Seizures __Chronic Colds
__Headaches __Asthma __Allergies __Digestive Problems
__ADHD __Recurrent Fevers __Growing Pains __Colic
__Bedwetting __Anemia __Reflux __Behavioral Problems
__Leg Problems __Poor Posture __Broken Bones __Heart Trouble
__Stomach Aches __Muscle Pain __Orthopedic Problem __Neck Problems
__Joint Problems __Constipation/diarrhea __Poor appetite __Arm Problems
__Back Problems __Walking Trouble __Sinus Trouble __Diabetes

Other:

_____

Number of doses of Antibiotics your child has taken:

_____

Please list any drugs or medications (prescription or over the counter) your child is taking:

_____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking:

_____

****Please skip *"Prenatal, Feeding, Developmental History"* if your child is 7 years or above.**

Prenatal History:

Name of Obstetrician/Midwife:

_____

Complications during Pregnancy: ___ No ___ Yes List: _____

Medications during Pregnancy/Delivery: ___ No Yes __ List: _____

Cigarette/Alcohol use during Pregnancy: ___ No ___ Yes List: _____

Location of Birth: __ Hospital __ Birthing Center __ Home

Birth Intervention: __ Forceps __ Vacuum Extraction __ Cesarean Section (emergency or planned?)

Complications during Deliver: __No __Yes List: _____

Genetic Disorder or Disabilities: __No __Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breastfed: ____ No ____ Yes How long? _____
Formula fed? ____ No ____ Yes How long? _____, which formula?_____

Does the baby prefer feeding on one side than the other? ____Yes ___ No

Introduced to solids at: _____ Months, Cows Milk at _____ Months.

Food/Juice Allergies, Sensitivities, or Intolerances: ___ Yes ___ No List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely be checked by a doctor of chiropractic for prevention and early detection of ***vertebral subluxation*** (spinal nerve interference).

At what age was your child able to:
_____ Respond to Sounds _____Cross Crawl _____Hold Head Up
_____Sit Up _____Stand Alone_____Walk Alone

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please (X) the appropriate answer to the following questions with the best of your ability.

Did your child have a traumatic birth? [ ] Yes [ ] No [ ] Unsure

Has your child had any serious falls? [ ] Yes [ ] No [ ] Unsure

Did/Does your child play youth sports? [ ] Yes [ ] No [ ] Unsure

Has your child been involved in a car accident? [ ] Yes [ ] No [ ] Unsure

Has your child been under chiropractic care? [ ] Yes [ ] No [ ] Unsure

On average, how many hours of sleep does your child get per night? _____

Bio-Chemical (Ages 3 and above)
Please write ***Never*** *(0 days),* ***Rarely*** *(1-2 days),* ***Occasionally*** *(3-5 days), or* ***Always*** *(6-7 days)* for the statements below. (Questions are based on days/week)

Does your child drink 2-8oz glasses of water?
_____
Does your child take a fish oil supplement?
_____

Does your child eat 4-8 servings of fruits & vegetables?

_____

Does your child eat splenda, or other artificial sweeteners?

_____

Does your child eat fast food?

_____

Does your child take medication?

_____

Does your child eat processed, packaged, or pre-made foods?

_____

Does your child eat sugary snacks, candies, or cereals?

_____

Does your child drink soda?

_____

Does your child eat white bread or pastas?

_____

Bio-Physical (Ages 5 and above)

Please write ***Never*** *(0 days),* ***Rarely*** *(1-2 days),* ***Occasionally*** *(3-5 days), or* ***Always*** *(6-7 days)* for the statements below. (Questions are based on days/week)

Do you feel your child's book bag is too heavy?

_____

Does your child get at least 1 hour of physical activity daily?

_____

Lifestyle (Ages 5 and above)

Please write ***Never*** *(0 days),* ***Rarely*** *(1-2 days),* ***Occasionally*** *(3-5 days), or* ***Always*** *(6-7 days)* for the statements below. (Questions are based on days/week)

Does your child have difficulty concentrating?

_____

Does your child complain of feeling overwhelmed or frustrated?

_____

Does your child get angry easily?

_____

Does your child feel confident in social settings?

_____

Financial Policies:

I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Global Health Chiropractic will prepare any necessary forms to assist me in making collection from the insurance company. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Dr. Baxter. However, I clearly understand and agree that all services rendered to me are my personal responsibility. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Informed Consent & Authorization to Treat a Minor:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Baxter and/or other licensed doctors of chiropractic who now or in the future work at Global Health Chiropractic, LLC.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed. I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Consent to treat a Minor: _____

Guardian or Spouse's Signature of Authorizing Care: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, and public health, research and law 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 for a fee within 14 days with a request.
- You may request to view 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, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy 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 quality 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 (Print)_____

Patient or Guardian Signature_____ Date_____