Case History / Patient Information

Children Birth - 12 Years

Date: __________________________________ Patient #: ______________ Doctor: _________________________________

Child's First & Last Name: ____

Street: ____ City: ____________________ State: _______ Zip: __________

Date of Birth: ____________________________ Age: ___________ Sex: M F Height: ________ Weight: _________

Siblings (Name and Age): ____

Medical Doctor: ________________________________ Previous Chiropractic Care: ______________________________

Referred To Our Office By: ____

Parent A (Main Contact)	Parent B
Name:	Name:
Cell Phone:	Cell Phone:
Employer:	Employer:
Email:	Email:

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating vertebral subluxations, or problem in the spine leading to interference in a healthy nervous system.

PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system.

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? ☐ Y ☐ N List: ____

Take any medications/supplements? ☐ Y ☐ N List: ____

Smoke, use illicit drugs or consume alcohol? ☐ Y ☐ N List: ____

Your child was born at: _______________ weeks gestation. Was labor artificially induced? ☐ Y ☐ N

Approximately how long did labor last? ___________ hours. Approximately how long did pushing last? ___________________

Was the child in a breech position (butt down) or otherwise mispositioned during labor/delivery? ☐ Y ☐ N

Please check where the child was born AND if any of the following were administered during labor and birth:

☐ Home birth/Birth Center ☐ Hospital birth ☐ Vaginal Delivery ☐ Caesarean Delivery
☐ Epidural/Spinal Tap ☐ Forceps Extraction ☐ Vacuum Extraction ☐ Medications
☐ Pitocin ☐ Episiotomy ☐ Water Birth ☐ Manual Traction of the Neck

Please check all that apply to the child's status immediately after birth: APGAR Score (final): __________

☐ Jaundice ☐ Respiratory problems ☐ Broken bones/Dislocations ☐ Cord Around Neck
☐ Feeding problem ☐ Odd Shaped Head ☐ Bruising ☐ Other

Please explain: ____

Patient Name: ____ *Patient #:* ___________ *Date:* _________________

Was your child breastfed? ☐ Y ☐ N For how long? ____

Formula Use? ☐ Y ☐ N For how long? ____

Cow's Milk Use? ☐ Y ☐ N For how long? ____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

☐ Uncoordinated/ Accident Prone ☐ Concussion ☐ Joint Dislocations
☐ Hospitalized ☐ Automobile Accident ☐ Chronic Illness
☐ Severe Trauma ☐ Bone Fractures ☐ Surgery

Explain: ____

Past & Present Medical History - *Please check if your child has or has had any of the following:*

□ Neck Pain	□ Colic	□ Muscle Spasm	□ Hepatitis
□ Middle Back Pain	□ Reflux	□ Eye/Vision Problems	□ HIV Positive
□ Low Back Pain	□ Sleeping Difficulties	□ Hearing Problems	□ Diabetes
□ Headaches/Migraines	□ Constipation	□ Asthma/Breathing Problems	□ Heart Condition
□ Arm Pain/Numbness/Tingling	□ Diarrhea	□ Menstrual Difficulties	□ Cancer
□ Leg Pain/Numbness/Tingling	□ Earache/Ear Infection	□ Depression	□ Stomach Problems
□ Hand Pain/Numbness/Tingling	□ Fever	□ Anxiety	□ Circulation Problems
□ Foot Pain/Numbness/Tingling	□ Bedwetting	□ Other Mental Disorders	□ Ulcers
□ Stiff Neck	□ Concentration Problems	□ Tension/Irritability	□ Epilepsy/Seizures
□ Joint Pain/Stiffness	□ Fatigue	□ Arthritis	□ Neurological Disorder
□ Dizziness/Loss of Balance	□ Scoliosis	□ Significant Weight Change	□ Weakness in Extremities
□ Fainting	□ Eczema	□ Other (list below)	

List and describe any other medical history not listed above:

____

____

List any physical activities your child participates in (sports, etc.): ____

Please check all that apply to your child and give any necessary details:

☐ Carries Backpack ☐ Excessive Technology Usage ☐ Prolonged Abnormal Positions (video games/reading/etc.)

Did your child meet all developmental goals on time? ☐ Y ☐ N If no, explain: ____________________________________

Did your child crawl on all fours? ☐ Y ☐ N If no, explain: ____

What is the date of your child's last physical exam/well child visit? ____

Has your child had any x-ray/CT/MRI/Ultrasound tests done in the past year? ☐ Y ☐ N

If yes, date and type of imaging performed: ____

Location/Doctor who performed the above imaging: ____

Patient Name: ____ *Patient #:* ___________ *Date:* _________________

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Please list any Medications and/or supplements your child is currently taking:

____

____

Have you chosen to vaccinate your child? ☐ Y ☐ N

If yes, is the child: ☐ Up To Date on all vaccinations ☐ On a Delayed Schedule

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

Please check all that apply and give any necessary details:

☐ Child exposed to secondhand smoke.

☐ Has allergies:

◻ Animals	◻ Pain Medication	◻ Shellfish/Iodine	◻ Chocolates/Sweets
◻ Dairy	◻ Penicillin	◻ Bee Stings	◻ Wheat
◻ Molds	◻ Other Medication	◻ Eggs	◻ Soaps
◻ Seasonal Allergies	◻ Latex	◻ Peanuts	◻ Polyester
◻ Dust	◻ Rubber	◻ Other:	

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs due to stress. Please indicate if your child has ever or is currently experiencing any of the emotional stressors below: (*check all that apply*)

☐ Academic Pressure
☐ Bullying
☐ Relocation
☐ Lifestyle Change
☐ Parent's Divorce
☐ New Sibling
☐ Loss of a Loved One
☐ Loss of a Pet
☐ Other: ___________________________

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Positive Chiropractic Solutions can best address for your child and/or what are your goals in bringing your child to our office today? ____

Please indicate below how these concerns are affecting your child's quality of life: (*check all that apply*)

☐ School
☐ Exercise/Sports
☐ Walking/Running
☐ Playing
☐ Sleep
☐ Attention/Focus
☐ Communication
☐ Eating
☐ Daily Routine

Patient Name: ____ *Patient #:* ___________ *Date:* _________________

FAMILY HISTORY

(Please Check all that Apply)

CONDITION	CHILD'S GRANDPARENTS **(PGF, PGM, MGF, MGM)** **Ex. Paternal Grandfather = PGF**	CHILD'S MOTHER	CHILD'S FATHER	SIBLING(S)
Arthritis				
Asthma				
Back Trouble				
Bursitis				
Cancer				
Constipation				
Diabetes				
Disc Problem				
Emphysema				
Epilepsy				
Headaches				
Heart Trouble				
High Blood Pressure				
Kidney Trouble				
Liver Trouble				
Migraine				
Neuralgia				
Pinched Nerve				
Scoliosis				
Sinus Trouble				
Stomach Trouble				
Stroke				
Other:				

If any of the above family members are deceased, please list with death cause:

____

____

I certify the information provided is accurate to the best of my knowledge:

Print Patient's Name:____

Print Legal Guardian's Name: ____

Signature of Legal Guardian:____ Date:_______________

IF your child has pain, what is their MAIN complaint? ____

Date problem began: _____________________ **How the problem began (falling, lifting, etc.)?** _________________________

How is their condition changing? ◻ GETTING BETTER ◻ GETTING WORSE ◻ NOT CHANGING

Have they had this condition in the past? ◻ YES ◻ NO **If yes, when was the last episode of this pain?** ___________

How often do they experience their symptoms?

◻ Intermittently (0-25% of the day) ◻ Occasionally (26-50% of the day)

◻ Frequently (51-75% of the day) ◻ Constantly (76-100% of the day)

Describe the nature of their symptoms:

◻ Sharp ◻ Dull ◻ Numb ◻ Burning ◻ Shooting ◻ Tingling ◻ Radiating Pain ◻ Tightness

◻ Stabbing ◻ Throbbing ◻ Other: ____

Please rate the pain on a scale of 1 to 10 (0 = NO PAIN and 10 = EXCRUCIATING PAIN)

◻ 1 ◻ 2 ◻ 3 ◻ 4 ◻ 5 ◻ 6 ◻ 7 ◻ 8 ◻ 9 ◻ 10

Does the pain radiate? ◻ YES ◻ NO **If yes, where does it radiate to?** ______________________________________

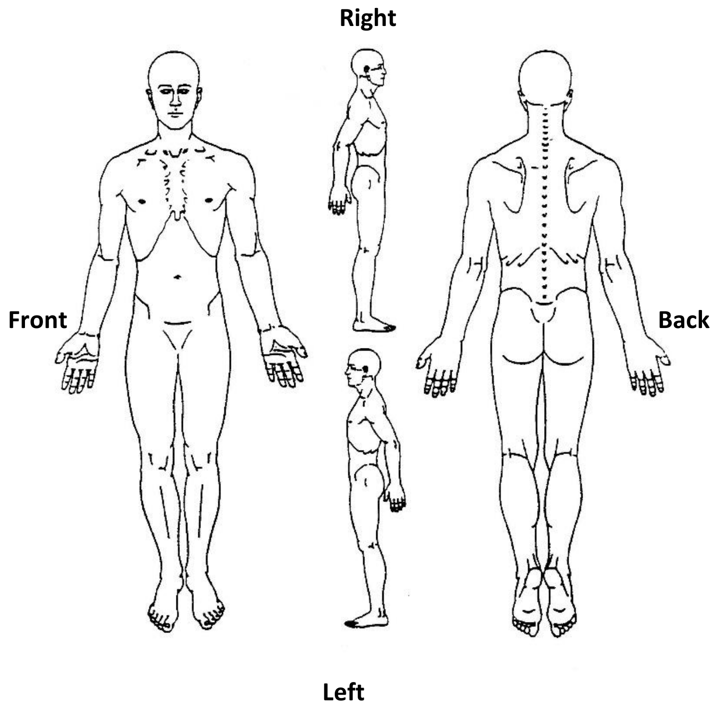
What activities make the condition WORSE (working, exercise, sitting, etc.)? ______________________________________

What activities make the condition BETTER (ice, heat, medication, etc.)? ____

How do the symptoms affect their ability to perform daily activities such as sports or school?

No problem 0 1 2 3 4 5 6 7 8 9 10 **Cannot perform activities**

PLEASE MARK THE AREAS OF PAIN ON THE DIAGRAM BELOW:



Main Reason for Consulting This Office:

- ◻ Become Pain Free
- ◻ Reduce Symptoms
- ◻ Resume normal activity level
- ◻ Explanation of my condition
- ◻ Learn how to care for my condition
- ◻ Second Opinion on my condition
- ◻ Wellness/Maintenance Care

Insurance:

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company:____

Name of Secondary Insurance Company (if any):____________________________________

By signing below, I understand and agree to allow this chiropractic office to use my child's Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my child's schedule of care as determined by their treating doctor, any fees for professional services will be immediately due and payable.

Print Patient's Name:____

Print Legal Guardian's Name: ____

Signature of Legal Guardian:_____________________________________ Date:____________

HIPAA Notice of Privacy Practices:

By signing below, I acknowledge receipt, understanding, and agreement to the HIPAA Notice of Privacy Practices of Positive Chiropractic Solutions. In addition, I understand and agree to allow this chiropractic office to use my child's Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. You have the right to know how your child's Patient Health Information is going to be used in this office and your rights concerning those records. A copy of our HIPAA Notice of Privacy Practices is available to you online and in our office. If you have questions regarding our Privacy Practices, please contact our Privacy Officer, Dr. Amanda M. Williams, D.C. at (850) 939-2200.

The following entity(ies) / person(s) have my permission to receive my child's personal health information:

Name / Relationship / Phone: ____

Name / Relationship / Phone: ____

Name / Relationship / Phone: ____

Print Patient's Name:____

Print Legal Guardian's Name: ____

Signature of Legal Guardian:_____________________________________ Date:____________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an 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.

Print Patient's Name:____

Print Legal Guardian's Name: ____

Signature of Legal Guardian:____ Date:________________

Name and address of clinic/office:
Positive Chiropractic Solutions
9200 Navarre Parkway, Suite E
Navarre, FL 32566

Print name(s) /doctor(s) treating this patient:
Dr. Amanda M. Williams, D.C.