# Pediatric Patient Form (Newborn – 17 years of age)

Welcome to Health Edge. We look forward to working with your family to achieve optimum health. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay even though there is no pain felt. A dentist checks for these "painless" cavities just as a chiropractor checks for spinal misalignment to maintain optimal health & development. Chiropractic does not cure any disease or treat symptoms alone. Rather, our chiropractic analysis will focus on removing nervous system interference, caused by physical, chemical, and/or emotional stressors, allowing the child's body to properly express health.

**To help us serve you better, please complete the following:** Date:_____

Child's Name_____ D.O.B. _____ Child's Age_____
SSN _____ Gender: M___ F___
Address_____ City/State/Zip_____
Parent Name(s)_____ Home phone_____
Cell #_____ Work #_____ Where do you prefer we call?_____
Names & Ages of Siblings_____
Parents Email Address_____
Legal Guardian (if other than parent): _____

**How did you hear about our office? Is there someone that we may thank for referring you to our office? _____**

**Please put a check next to the purpose of your child's visit (mark all that apply):**
*Crisis Management____* *Early Detection of Problems____* *Prevention____*
*Wellness____* *Maximizing Normal Growth & Development____* *Other____*

## BIRTH HISTORY

Type of Labor: Easy_____ Moderate_____ Difficult_____ IV Pain Meds_____ Epidural_____
Type of Delivery: Vaginal_____ Forceps_____ Suction Cup or Vacuum_____ C-section_____
Location: Home_____ Birth Center_____ Hospital_____
Problems During Pregnancy:_____
Problems During Labor/Delivery:_____
Was child born: Cephalic (head first) ____ Breech (feet first) ____
Problems at Birth: Jaundice (yellow)_____ Cyanosis (blue)_____ Congenital Anomalies_____
Was mother under Chiropractic care during pregnancy? Yes____ No____

## VITAL HEALTH INFORMATION

Current Weight: _____ Current Height or Length:_____
Do you notice any developmental delays with your child? Yes____ No____
If yes, please explain:_____

## CURRENT HEALTH CHALLENGE

Major_____ Minor_____
When did this problem begin?_____
Is this problem: Occasional___ Frequent___ Constant___ Intermittent___
Does problem radiate? Yes___ No___ If Yes, where? _____
What makes this worse?_____
What makes this better?_____
Is the problem worse during a certain time of the day? Yes___ No___ If Yes, when?_____
Does this interfere with: School____ Sleep____ Eating____ Daily Routine ____
Is this becoming worse? Yes___ No___

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health, if any:_____

Often seemingly unrelated symptoms can manifest as other health concerns. Please check if your child has experienced any of these health challenges:

| | | |
|---|---|---|
| __Headaches | __Learning Disorder | __Behavioral Disorder |
| __Ear Infections/Pain | __Menstrual problems/cramps | __Muscle cramps |
| __Seizures | __Breathing problems (Asthma) | __Growing pains |
| __Dizziness | __Jaw Problems | __Eating Disorder |
| __Depression | __Bed wetting/urinary problems | __Numbness |
| __Fainting | __Irritability | __Weakness |
| __Allergies | __Sinus problems | __Sleeping problems |
| __Accident Prone | __Colic | __Fatigue |
| __Constipation | __Diarrhea | __Neck/Back problems |
| __Hyperactivity | __Heartburn | __Stiffness |
| __Loss of Concentration | __Frequent Colds/Flu | __Scoliosis/Poor Posture |
| __Loss of Smell | __Diabetes | __Acne/Rashes |
| __Loss of Taste | __High Blood Pressure | __Pneumonia |
| __Ears buzzing | __Vision changes | __Frequent sore throats |

Other: _____

How long has your child been living this way? Weeks_____ Months_____ Years_____
Would you like to find the cause of your child's problem(s)? Yes_____ No_____ Maybe_____
If so, what result would you want for your child?_____

How does your child's current health affect his/her daily life? Restricted in daily activities_____
Hindering ability to participate in sports/activities/exercise_____ Trouble at school_____
Difficulty interacting with others_____ Creates family stress_____ Other_____

*Since problems that Chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us:*

Has this child ever experienced the following spinal traumas?

| | | |
|---|---|---|
| __Fall in baby walker | __Fall from bed or couch | __Fall from crib |
| __Fall off swing | __Fall off bicycle | __Fall off skateboard or skates |
| __Fall from high chair | __Fall off slide | __Fall down stairs |
| __Fall from changing table | __Fall off monkey bars | __Other_____ |

Any sports played? Y__ N__ If yes, what sport(s)?_____
Any broken bones or injuries? Y__ N__ If yes, please explain_____
_____
Ever been involved in an auto accident? Y__ N__ If yes, please explain_____
_____
Any hospitalizations or surgeries? Y__ N__ If yes, please explain_____
_____

Quality of Sleep: Good___ Fair___ Poor___ # of hours of sleep per night_____

Was (or is) this child breast-fed? Yes__ No__ If yes, how long? _____
Formula introduced at what age? ____

**CURRENT HABITS**

Diet high in? Fruits___ Veggies___ Water___ Pop/Soda/High Sugar Fruit Drink Intake___
White Sugar___ Dairy___ Gluten (flour)___ Processed Foods___
Does your child overall partake in "high" or "low" levels of activity/exercise? High__ Low__
Smoke?___ Drink?___
Excessive use of Television/Computer/Video Games?____

**MEDICAL CARE**

Pediatrician/Family Doctor:_____ City, State:_____
Date of Last Visit:_____ Reason:_____
Vaccinations: all_____ some_____ none_____
Number of antibiotics taken: In the past 6 months_____ During his/her lifetime_____
Has your child ever been treated on an emergency basis?_____ Please explain_____
List, if any, current or past medications, and why being taken:_____
_____

**CHIROPRACTIC CARE**

Has your child ever received Chiropractic care? Yes__ No__ (If yes, please provide info below)
Dr.'s Name_____ Reason_____
Results_____ Date of last visit_____

Has your child ever received NUCCA care? Yes__ No__ (If yes, please provide info below)
Dr.'s Name_____ Reason_____
Results_____ Date of last visit_____

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and should I desire credit to be extended, I authorize any necessary credit verification. I also understand that if I suspend or terminate my care, fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 1% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_____ _____
Signature of Patient or Guardian Date

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**DO NOT WRITE BELOW THIS LINE**

X-Rays ☐ Yes ☐ No ☐ Consultation Only

**AUTHORIZED & INFORMED CONSENT FOR NUCCA CHIROPRACTIC CARE**

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. 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 adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. We will assess your specific condition, overall health, and, in particular, your spinal health. This will assist us in determining if upper cervical care is needed or if any further examinations or studies are needed before initiating care. All relevant findings will be reported to you prior to care.

We do not offer to diagnose or provide care for any disease or condition other than your Upper Cervical (Atlas) Subluxation. However, if during the course of evaluation and care we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only goal is to allow the body to do its job.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

_____ _____

Patient Name (PRINTED) Relationship to Patient

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Signature (Office Staff) Date