

# Health Story: Infant/Child Practice Member

## Vital Information

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Prefers to be called \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Gender F | M

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s)/Guardian(s) Names & Relationships \_\_\_\_\_

\_\_\_\_\_

Home # \_\_\_\_-\_\_\_\_-\_\_\_\_ Work # \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell # \_\_\_\_-\_\_\_\_-\_\_\_\_

Preferred contact # H | W | C Email \_\_\_\_\_

Names & Ages of Siblings (if applicable) \_\_\_\_\_

\_\_\_\_\_

Who can we thank for referring you to *Total Health & Rehab* or how did you hear about our office

\_\_\_\_\_

Has your child ever been adjusted by a Chiropractor? Y | N For how long \_\_\_\_\_

Who & Where? \_\_\_\_\_ Date of last adjustment? \_\_\_\_/\_\_\_\_

Who else is on your child's health care team? (Name of obstetrician, midwife, MD or other health care provider) \_\_\_\_\_

\_\_\_\_\_

Date of last visit? \_\_\_\_/\_\_\_\_ Reason for visit \_\_\_\_\_

Reason for seeking *Total's* Services? \_\_\_\_\_

What other action steps have you taken? \_\_\_\_\_

\_\_\_\_\_

Please list any other health concerns your child may be experiencing \_\_\_\_\_

\_\_\_\_\_

Is there anything about your child's Nerve System or Spine that we should know about?

\_\_\_\_\_

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Chiropractic care is based on the concept that the nervous system coordinates the growth, motion, sensations, immunity and overall health of your body. This vital system is protected by the bony spine, skull and pelvis. It is vital to have clear and open communication between the brain and body. Having tension and imbalances in the spinal ligaments and musculature, as well as misalignments in the bony spine can cause interference in the body's natural ability to heal and thrive.

Many of the health challenges that people face originate from stressors experienced during their birth, and developmental years. These stressors (traumas) may be any chemical, emotional or physical stress that your child's body cannot properly perceive, adapt to and integrate. *Total Health's* goal is to help your child's body release stored tension and the more we know about your child's health stressors, the more we can help with their healing process. *Please answer the following questions pertaining to him/her to the best of your ability.*

## **Pregnancy & Birth Experience** *(if known, please answer all that apply to your child's*

Were any of the following used by the mother while pregnant?

Prenatal vitamins | Cigarettes | Alcohol | Caffeine | OTC Drugs | Prescription Drugs | Recreational Drugs

Please Explain Type and Frequency \_\_\_\_\_

Ultrasound Y | N Frequency \_\_\_\_\_ Twins/Triplets Y | N

Was Labor Induced Y | N at how many weeks? \_\_\_\_\_ Why? \_\_\_\_\_

Duration of labor \_\_\_\_\_

Location of Birth: Home birth | Hospital | Birth Center | Other \_\_\_\_\_

Birth Assistants: Spouse/ Partner | Midwife | Doula | Medical Doctor | other family member/friend

Type of labor: Cephalic (head first) | Breach (feet first) | VBAC (vaginal birth after Cesarian)

Was there any complications during pregnancy and/or birth? Y | N \_\_\_\_\_

Did mother receive any drugs? Pitocin | Epidural | Other: \_\_\_\_\_

Was there any assistance needed during birth? Vacuum Extraction | Forceps | Cesarian

Was there evidence of birth trauma to infant? Bruising | Fetal Distress | Other \_\_\_\_\_

Congenital Birth Anomalies/ Defects \_\_\_\_\_

Additional Comment(s) \_\_\_\_\_

## **Growth & Development** *(if known, please answer all that apply to your child)*

Was your child breast fed? Y | N For how long? \_\_\_\_\_ Formula Fed? Y | N For how long? \_\_\_\_\_

At what age were solids introduced (ex. cereal) ? \_\_\_\_\_ Vitamins? Y | N \_\_\_\_\_

Is your child gaining weight normally? Y | N Does your child have a healthy appetite? Y | N

Is your child having regular Bowel Movements? Y | N \_\_\_\_\_

Age Stool trained: \_\_\_\_\_ Age Urine Trained: \_\_\_\_\_

Hours of sleep per night \_\_\_\_\_ Quality of sleep: Good | Fair | Poor

When did your child:

Hold head up \_\_\_\_\_ Roll Over \_\_\_\_\_ Sit Alone \_\_\_\_\_ Crawl \_\_\_\_\_

Begin on feet \_\_\_\_\_ Walk \_\_\_\_\_ Was a walker or bouncer ever used? Y | N

Additional Comment(s) \_\_\_\_\_

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## Physical, Chemical & Emotional Stressors

### Physical Stressors *(Please circle the stressors your child may have experienced)*

				<i>Explain</i>
Serious Slips/ Falls	Past	Recent	Never	_____
Car Accidents	Past	Present	Never	_____
Sports Injuries	Past	Present	Never	_____
Physical/ Sexual Abuse	Past	Present	Never	_____
Poor Posture	Past	Present	Never	_____
Extensive Computer Time	Past	Present	Never	_____
Extensive Video Games	Past	Present	Never	_____
Not Enough/ Poor Sleep	Past	Present	Never	_____
Carrying Heavy Backpack	Past	Present	Never	_____
Surgery/ Stitches	Past	Present	Never	_____
Bone Fracture	Past	Present	Never	_____
Other	Past	Present	Never	_____

### Chemical Stressors *(Please circle the stressors your child may have experienced)*

				<i>Explain</i>
Antibiotics	Past	Recent	Never	_____
Second Hand Smoke	Past	Present	Never	_____
High Sugar Intake	Past	Recent	Never	_____
Environmental (ex. poor air/ water)	Past	Present	Never	_____
Fast Food	Past	Recent	Never	_____
Caffeine	Past	Present	Never	_____
Artificial Sweeteners	Past	Recent	Never	_____
Prescription Drugs	Past	Present	Never	_____
Exposure to Chemicals/ Poisons	Past	Recent	Never	_____
Over the Counter Drugs (ex. Advil)	Past	Present	Never	_____
Vaccinations	Past	Recent	Never	_____
Other	Past	Present	Never	_____

### Emotional Stressors *(Please circle the stressors your child may have experienced)*

				<i>Explain</i>
Divorced/ Separated Parents	Past	Recent	Never	_____
Bullying/ Teased	Past	Present	Never	_____
High Family Stress	Past	Recent	Never	_____
Perfectionist Personality	Past	Present	Never	_____
Behavioral or Social Problems	Past	Recent	Never	_____
Sickness/ Loss of Loved One	Past	Present	Never	_____
Verbal/ Emotional Abuse	Past	Recent	Never	_____
Body Image Issues	Past	Present	Never	_____
Other	Past	Recent	Never	_____

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## System Challenges

Has your child's body communicated any of the following to you? Although these may seem unrelated to the reason you are seeking care for your child, their nervous system coordinates all their body functions and these could serve as indicators that their nervous system is being challenged. Please mark all that apply.

- |  |   |  |
|--|---|--|
| <input type="radio"/> Neck Pain              | <input type="radio"/> Heart Conditions            | <input type="radio"/> Bed Wetting          |
| <input type="radio"/> Headaches              | <input type="radio"/> Anemia                      | <input type="radio"/> Fainting             |
| <input type="radio"/> Allergies              | <input type="radio"/> Numbness or Tingling        | <input type="radio"/> Torticollis          |
| <input type="radio"/> Ringing in Ears        | <input type="radio"/> Sweats/ Chills              | <input type="radio"/> Joint Problems       |
| <input type="radio"/> Vertigo/ Dizziness     | <input type="radio"/> Fatigue                     | <input type="radio"/> Meningitis           |
| <input type="radio"/> Nose Bleeds            | <input type="radio"/> Asthma/ Breathing Problems  | <input type="radio"/> Chicken Pox          |
| <input type="radio"/> TMJ                    | <input type="radio"/> Back Aches                  | <input type="radio"/> Measles              |
| <input type="radio"/> Sinus Problems         | <input type="radio"/> Constipation/ Diarrhea/ Gas | <input type="radio"/> Whooping Cough       |
| <input type="radio"/> Decreased Taste/ Smell | <input type="radio"/> Digestion/ GI Problems      | <input type="radio"/> Paralysis            |
| <input type="radio"/> Chronic Fever          | <input type="radio"/> Stomach Problems            | <input type="radio"/> Febrile Seizures     |
| <input type="radio"/> Anxiety                | <input type="radio"/> Urinary Changes             | <input type="radio"/> Scoliosis            |
| <input type="radio"/> Depression             | <input type="radio"/> Diabetes                    | <input type="radio"/> Hernias              |
| <input type="radio"/> ADD/ ADHD              | <input type="radio"/> Insomnia                    | <input type="radio"/> Repeated antibiotics |
| <input type="radio"/> Colic                  | <input type="radio"/> Poor Appetite               | <input type="radio"/> Behavioral Problems  |
| <input type="radio"/> Rashes/ Eczema         | <input type="radio"/> Tubes in Ears               | <input type="radio"/> Difficulty Latching  |
| <input type="radio"/> Other _____            | <input type="radio"/> Other _____                 | <input type="radio"/> Other _____          |

## Clarifying Your Intentions

People see chiropractors for a variety of reasons. Some go for the relief of symptoms, some go to correct the *origin* of the symptoms and others go to balance their body and optimize their vitality and health. What changes in your child's health or behavior would you like to see? (i.e. abundant health, increased immunity, pain relief, balanced body, better adaptability to life stressors, etc.) \_\_\_\_\_

**I have reviewed and certify that all of the information that I have reported above is true to the best of my knowledge.**

Practice Member Name \_\_\_\_\_ Parent/ Guardian Name \_\_\_\_\_

Parent/ Guardian Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Welcome to Total Health...

Thank you for choosing Total Health & Rehab Family Chiropractic and giving us the opportunity to serve you! We are committed to providing you an exceptional chiropractic and healing experience. We are excited to work with you and help you thrive in an active and healthy lifestyle. If at any time during care you have questions, please do not hesitate to ask. All of your questions, even ones you haven't thought of yet, will be answered on your second visit during your doctor's report. We look forward to you joining our health family.

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## Authorization

- I give permission to Total Health & Rehab to use my address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about healthcare and health related information.
- If Total Health contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give Total Health & Rehab permission to use my name on a welcome board and referral board
- I give Total Health & Rehab permission to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give Total Health & Rehab permission to use any testimonial written by me for informational purposes such as sharing with other clients, prospective clients, in brochures, on their website, or in ads in print media.
- I give Total Health & Rehab permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my health information during the course of care. Should I need to speak with the chiropractor at any time in private, the chiropractor will provide a room for these conversations.
- By Signing this form, you are giving Total Health & Rehab permission to use and disclose your protected health information with the directives listed above.

This authorization will remain in effect for the duration of my care at Total Health & Rehab or until revoked by me. You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to Total Health & Rehab. The written notice must contain the following information: your name, social security number, date of birth, a clear statement of your intent to revoke this authorization, date of request and your signature. The revocation is not effective until it is received by Total Health.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Total Health & Rehab will still provide care. A copy of this signed form will be provided upon request.

Printed Name of Child: \_\_\_\_\_ Name of Parent/ Guardian \_\_\_\_\_

Parent/ Guardian Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## Terms of Acceptance

Our purpose in sharing this statement of clinical objectives is to clearly define our approach to Chiropractic, healing and those we serve in this office. We wish to clearly communicate our responsibilities in this exciting relationship. The following concepts are central to the way in which we practice Chiropractic. We are pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

There is intelligence within each individual that not only keeps that person alive, but also coordinates, repairs, renews and heals every cell of the body. The nervous system is the main distribution center and coordinating system for this innate intelligence. Proper coordination, repair, movement, healing and genetic potential cannot be fully expressed when this life power and intelligence is blocked or redirected. The purpose of chiropractic adjustments given in this office is to correct vertebral subluxations, allowing a greater communication of this life power and coordinating intelligence thus promoting better health.

Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible and subluxation-free spine and nervous system. Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change. Specific location of symptoms does not correlate to specific subluxations needing to be adjusted. Severity of symptoms does not correlate to severity of subluxations. The reduction of symptoms is not an effective indicator of improved health. An individual may have symptoms and not need an adjustment on a particular visit. An individual may have no symptoms and may require extensive adjustments on a particular visit. A person's symptoms are not necessarily in direct relationships to his or her prognosis. We do not treat specific symptoms, conditions or ailments, other than vertebral subluxations. We do not imply that any particular adjustment or series of adjustments will have a direct effect on any symptoms or condition a person may be presenting. Research studies show thousands of patients receiving chiropractic adjustments report improved physical and emotional health and well-being. We encourage any individual having concerns about symptoms or ailments to consult with a disease or symptom care specialist.

By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time required for spinal correction. Medication levels for an inflexible body-mind stuck in sickness are not necessarily the same as for a body becoming well. We will not venture into the practice of medicine by advising about the need for reduction of medications. We suggest you speak with your physician to determine the objective and goal to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind. Consistent with the above concepts, we locate and adjust vertebral subluxations using the techniques we believe to be the most honoring and effective.

At Total Health & Rehab, we educate our practice members as to the inherent healing capabilities of the human body. We encourage and empower our practice members to become aware and responsible for their wellbeing. Our intention is to provide you with the best care that we can offer as described above. We do not offer care with the intent of "treating" or "curing" disease or conditions. If during the course of care we encounter non-chiropractic unusual findings, we will advise you of those findings and recommend that you see the services of another health care provider.

## Informed Consent

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 include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health story and spinal examination will be completed. These procedures are performed to assess your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is appropriate, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

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 chiropractic care including spinal adjustments, as reported following my assessment.

I \_\_\_\_\_ have completely read and understand the above statements on behalf of my child \_\_\_\_\_ and choose to have him/her receive care.

Parent/ Guardian Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_