



## ABOUT THE CHILD

CHILD'S NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
DATE OF BIRTH:	AGE:	
GENDER:	HEIGHT:	WEIGHT:

## ABOUT THE PARENT'S

PARENT'S NAMES:	
ADDRESS:	
<input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER:	

## CHILD'S HEALTH HISTORY

**INSTRUCTIONS:** Please check each of the diseases or conditions that the child now has or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> IRRITABILITY
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> SKIN PROBLEMS
<input type="checkbox"/> ATTENTION PROBLEMS	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DISORDERS
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> FREQUENT COLDS	<input type="checkbox"/> TUBES IN THE EARS
<input type="checkbox"/> BREATHING PROBLEMS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> COLIC	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> GROWING PAINS
<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> OTHER: _____

## VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
HOW MANY VACCINATIONS HAS YOUR CHILD HAD? <input type="checkbox"/> ALL <input type="checkbox"/> MOST <input type="checkbox"/> SOME EXPLAIN:
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S): <input type="checkbox"/> FEVER <input type="checkbox"/> LETHARGY <input type="checkbox"/> FUSSINESS <input type="checkbox"/> SEIZURES

## CHIROPRACTIC EXPERIENCE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR WELLNESS CENTER BECAUSE OF (CHECK ALL THAT APPLY): <input type="checkbox"/> FRIENDS & FAMILY <input type="checkbox"/> CO-WORKERS <input type="checkbox"/> INTERNET <input type="checkbox"/> MAILING <input type="checkbox"/> SIGN <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> NEWSPAPER
HAS YOUR CHILD BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> WELL CHECK <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES <input type="checkbox"/> SCHOOL <input type="checkbox"/> PLAY <input type="checkbox"/> BEHAVIOR PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

## MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE: <input type="checkbox"/> DRUGS/MEDICATIONS <input type="checkbox"/> TOBACCO/ALCOHOL IF YES, PLEASE EXPLAIN:
WAS THE BABY EVER IN THE BREECH POSITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW MANY? _____
DESCRIBE YOUR DELIVERY:  <input type="checkbox"/> LABOR WAS CHEMICALLY INDUCED <input type="checkbox"/> EPIDURAL <input type="checkbox"/> C-SECTION DELIVERY <input type="checkbox"/> FORCEPS/VACUUM EXTRACTION <input type="checkbox"/> DOCTOR PULLED OR TWISTED BABY <input type="checkbox"/> PREMATURE DELIVERY <input type="checkbox"/> HOME BIRTH <input type="checkbox"/> WATER BIRTH <input type="checkbox"/> DULA/MIDWIFE ASSISTED PLEASE EXPLAIN:
HOW LONG WAS THE LABOR? _____ HOW LONG WAS THE DELIVERY? _____
DID YOU EXPERIENCE ANY ILLNESS(S)/COMPLICATIONS WHILE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DID YOU BREASTFEED? <input type="checkbox"/> YES   HOW LONG? _____ <input type="checkbox"/> NO
DID YOU EXPERIENCE FEEDING PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID YOUR BABY HAVE COLIC? <input type="checkbox"/> YES <input type="checkbox"/> NO
VACCINATIONS DURING PREGNANCY? (EX. FLU SHOT) <input type="checkbox"/> YES <input type="checkbox"/> NO

## ARE YOU AWARE THAT

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? <input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? <input type="checkbox"/> YES <input type="checkbox"/> NO

## CHILD'S CURRENT HEALTH

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF DOSES _____ PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER FALLEN FROM A HEIGHT OVER 3 FEET? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
IS YOUR CHILD ACCIDENT PRONE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS? <input type="checkbox"/> YES <input type="checkbox"/> NO   PLEASE EXPLAIN:
HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR? <input type="checkbox"/> YES <input type="checkbox"/> NO   PLEASE EXPLAIN:
WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

### Consent to evaluate and adjust a minor child

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care. In addition, the statements made on this form are accurate to the best of my recollection.

\_\_\_\_\_  
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 body. This can cause pain or 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 is called, 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 statement. 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.*

## 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, 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 within 30 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 (HIPAA), 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 (Please Print)

\_\_\_\_\_  
Relationship to Patient (If Patient is a Minor)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the doctor and associates of Swenson Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date