whole life
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)

First Name:_____ Middle :_____Last:_____ Today's date:_____

Nick-Name _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ____/____/_____ Sex: _____ Weight: _____ Height: _____ Race/Ethnicity:_____ Preferred Language:_____

Whom may we thank for referring you to our office? _____

Father's Name and Cell phone:_____ Mother's Name and cell phone: _____

Home Phone:_____ Email:_____ _____

Parent's marital status (please circle): Single Married Divorced Widowed

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 about yourself or the other members of your family:

Yourself/Spouse:_____

Other Children:_____

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	__Dizziness
__Headaches	__Asthma	__Allergies	__Digestive Problems	__Numbness
__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 rounds 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: _____Was the baby carried to full term?_____

Complications during Pregnancy: ___ No ___ Yes List: _____

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

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

Any exposure to ultrasound? _____How many?_____

Location of Birth: __ Hospital __ Birthing Center __ Home

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

Complications during Delivery: __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. What were the first solids?_____

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

Did your child skip and developmental steps? (ex: went straight to walking, didn't crawl)_____

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)

(Questions are based on days/week)	Never (0 days)	Rarely (1-2days)	Occasionally (3-5 days)	Always (6-7 days)
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 & veggies?	[ ]	[ ]	[ ]	[ ]
Does your child 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-Phyiscal (Ages 5 and above)

How much physical activity does your child get a day?_____

How does your child carry their school books?_____ _____About how heavy is their bag?_____

How much of TV does your child watch a day?_____ On the computer? _____ Playing video games?_____

Lifestyle (Ages 5 and above)

(Questions are based on days/week)	Never (0 days)	Rarely (1-2days)	Occasionally (3-5 days)	Always (6-7 days)
Does your child have difficulty concentrating?	[ ]	[ ]	[ ]	[ ]
Does your child ever feel overwhelmed or frustrated?	[ ]	[ ]	[ ]	[ ]
Does your child get angry easily?	[ ]	[ ]	[ ]	[ ]
Does your child feel confident in social settings?	[ ]	[ ]	[ ]	[ ]

Are we coordinating care with your physician?:

I would like a copy of NO YES my records sent to my physician
(Circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other
Dr.'s Name:_____
Clinic's Name & Location_____

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Whole Life Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Whole Life Chiropractic will be credited to my account upon receipt. 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. Murphy. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. 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. If payment hasn't been received in 10 days from terminating care, I authorize deduction from my credit card.

Please Note: Insurance companies do not pay for care that is not medically-necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage.

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. Nicole and/or other licensed doctors of chiropractic who now or in the future work at Whole Life Chiropracitc, PA.
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: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient's Signature: _____ Date: _____