Ireland Chiropractic Clinic Chiropractic Children's Health History Form

Today's Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Home phone (_____) _____	Home phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

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

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Ireland Chiropractic Clinic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

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

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** 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 caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:

❑ Experience any significant illnesses, difficulties, or trauma? _____

❑ Take any drugs/medications? _____

❑ Smoke or consume alcohol

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ❑ No ❑ Yes _____

Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____

❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____

❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

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.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT	_____	❑ MMR	_____	❑ Other	_____
❑ Polio	_____	❑ Chicken Pox	_____		
❑ Hepatitis	_____	❑ Flu	_____		

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

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

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

Finances

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing. The first visit fee is $65 if no xrays, $165 with xrays.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

PLEASE READ AND SIGN

1. I acknowledge that Ireland Chiropractic Clinic has informed me that Dr. Jessica Steenstre is in network with certain insurance companies. It is a courtesy for Ireland Chiropractic Clinic to find out benefit information but it is NOT a guarantee of coverage. Insurance companies hold the right to deny care if not seen as medically necessary. Insurance companies also do NOT cover wellness or preventive care. Therefore any care deemed as wellness or preventive will not be billed to insurance company and is 100% patient responsibility.
2. I have been informed that all deductible amounts must be paid by me at time of service. I have also been informed that any changes to insurance policy (ie. New cards, new carrier) is my responsibility to supply this information to Ireland Chiropractic Clinic or charges will become my responsibility.
3. I have been informed that a copy of Ireland Chiropractic Clinic *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office.
4. I consent to receive communication from Ireland Chiropractic Clinic via email, postal mail, text and telephone messaging in conection with my care.
   ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
5. I consent to being treated in an open adjusting area. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing and then be treated in a closed room.
6. I clearly understand that Dr. Jessica Steenstra is not responsible for any pre-existing medical diagnosis. I also understand that if for any reason my child's care is terminated, any professional fees for services rendered will become immediately due and payable.
7. I have been informed that I am being treated for vertebral subluxation NOT any disease or condition that may have been diagnosed by another healthcare professional. Our goal at Ireland Chiropractic Clinic is to treat by specific adjustments to correct vertebral subluxations.
8. I consent that the following is a secondary contact to be used for an emergency or I cannot be reached.

   Name:
   Address:
   Phone Number:

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Jessica Steenstra permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Ireland Chiropractic Clinic.

We look forward to helping you!