Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_
Parent’s Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s SS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Height: \_\_\_\_ft \_\_\_\_in Weight: \_\_\_\_\_\_lbs
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who can we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child received chiropractic care in the past? 🗌 YES 🗌 NO (from whom?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Who is your child’s primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Is your child receiving care from any other health professionals? 🗌 YES 🗌 NO from whom & their specialty? \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list any drugs/medications/vitamins/herbs/other that your child is taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out the following information completely and to the best of your ability.

Purpose of this visit: 🗌 Wellness Checkup 🗌 Injury or Accident

Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is experiencing pain/discomfort – please identify where and for how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the condition first begin \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ 🗌 Suddenly 🗌 Gradually 🗌 Post-Injury
Is this condition: 🗌 Getting worse 🗌 Improving 🗌 Intermittent 🗌Constant 🗌 Unsure
Has your child ever had this problem before? 🗌 YES 🗌 NO If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What makes the problem better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What makes the problem worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **HEALTH GOALS FOR YOUR CHILD**

|  |  |
| --- | --- |
| What are your top three health goals for your child? | What would you like to gain from chiropractic care? |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  🗌 Resolve existing condition |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  🗌 Overall wellness |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  🗌 Both |

**HEALTH, VITALITY & CHIROPRACTIC CARE**

The primary system in the body which coordinates health is the nervous system. The vertebra, bones of the spinal column, surround and protect the delicate nervous 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 subluxation can have physical, emotional, and chemical causes and effects.

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL, and EMOTIONAL 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 played a part in creating vertebral subluxation.

**BIRTH & PREGNANCY HISTORY**
The birth process can be traumatic to a baby’s spine & cause interference to the nervous system

|  |  |  |
| --- | --- | --- |
| Any fertility issues? | 🗌 YES 🗌 NO | If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did mother smoke? | 🗌 YES 🗌 NO | If yes, how many per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did mother drink? | 🗌 YES 🗌 NO | If yes, how many per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did mother exercise? | 🗌 YES 🗌 NO | If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Was mother ill? | 🗌 YES 🗌 NO | If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any ultrasounds? | 🗌 YES 🗌 NO | If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please check where the child was born and if any of the following were administered during labor and birth

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🗌Home birth | 🗌Hospital birth | 🗌Vaginal | 🗌Water birth | 🗌Caesarean |
| 🗌Epidural | 🗌Forceps | 🗌Vacuum | 🗌Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🗌Pitocin | 🗌Episiotomy | 🗌Manual traction of the neck |

Please check all that apply to the child’s status immediately after birth:

|  |  |  |
| --- | --- | --- |
| 🗌Jaundice | 🗌Respiratory problems | 🗌Broken bones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🗌Feeding problems | 🗌Displaced joints | 🗌Other conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Was the baby breastfed? 🗌YES 🗌NO For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL STRESS: INFANCY & CHILDHOOD -** Please check all that apply to your child and give any necessary details:

🗌 Uncoordinated/Accident prone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🗌 Has been hospitalized \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🗌 Had a severe trauma or concussion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🗌 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHEMICAL STRESS**
Chemical stress 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? 🗌YES 🗌NO 🗌On Schedule 🗌 Delayed Schedule
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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 *(check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| 🗌 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

 **HAS YOUR CHILD EVER SUFFERED FROM:** *(check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| 🗌 Headaches | 🗌 Orthopedic Problems | 🗌 Digestive Disorders | 🗌 Behavioral Problems |
| 🗌 Dizziness | 🗌 Neck Problems | 🗌 Poor Appetite | 🗌 ADD / ADHD |
| 🗌 Fainting | 🗌 Arm Problems | 🗌 Stomach Aches | 🗌 Ruptures/Hernia |
| 🗌 Seizures/Convulsions | 🗌 Leg Problems | 🗌 Reflux | 🗌 Muscle Pain |
| 🗌 Heart Troubles | 🗌 Joint Problems | 🗌 Constipation | 🗌 Growing Pain |
| 🗌 Chronic Earaches | 🗌 Backaches | 🗌 Diarrhea | 🗌 Asthma |
| 🗌 Sinus Troubles | 🗌 Poor Posture | 🗌 Hypertension | 🗌 Walking Troubles |
| 🗌 Scoliosis | 🗌 Anemia | 🗌 Colds/flu | 🗌 Sleeping Problems |
| 🗌 Bedwetting | 🗌 Colic | 🗌 Broken Bones | 🗌 Fall off swing |
| 🗌 Fall in baby walker | 🗌 Fall from bed or couch | 🗌 Fall from crib | 🗌 Fall down stairs |
| 🗌 Fall off bicycle | 🗌 Fall from high chair | 🗌 Fall off slide |  |
| 🗌 Fall from changing table | 🗌 Fall off monkey bars | 🗌 Fall off skateboard/skates |  |

**YOUR EXPECTATIONS FROM CHIROPRACTIC CARE**

I would like my child to experience the following benefits from Chiropractic Care. *(check all that apply)*

🗌 Symptomatic relief of a problem

🗌 Prevention of future problems

🗌 Healthier spine and nervous system

🗌 Optimal health on all levels

🗌 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written Consent for a Child

I authorize Dr. Devan Mahan and any and all Mahan Family Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Mahan Family Chiropractic.

I understand that I am directly and fully responsible to Mahan Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

🗌 Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

*Failure to cancel a scheduled appointment without a 24-hour notice or “no-showing” the scheduled appointment will results in a charge on the patient's account for the full amount of the missed visit*.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
**Parent or Legal Guardian’s Signature Date Completed**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
**Doctor’s Signature Date Form Reviewed**