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Pediatric/Youth Health Profile (Ages 12 and under)

*Please do your best to fill out *everything* on this intake form. It is important that I understand past and current stressors that may have affected or could affect your child's health. It is important for me to know the following information, even if it may not seem relevant to the reason for which you are coming in for care. Please know that I value your time and aim to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic!

Check type of care desired: __Temporary Relief / __Stabilization / __Family Health/ Prevention/ __Doctor's Advice

Child's Name _____ DOB _____ Age _____ Sex _____

Siblings' Names and Ages: _____

Parent's Name _____ Work Phone _____ Cell _____

Parent's Name _____ Work Phone _____ Cell _____

Address _____ City_____ State_____ Zip Code _____

Home Phone _____ Email _____

Who referred you to our office? _____

Current Concerns

What is the reason for your appointment? _____

_____

When did this situation or concern first begin? _____

Is this related to an ___ auto accident ___ injury Notes: _____

Have you done anything for or gotten any advice or treatment for this issue outside of this office? Yes No
Explain:_____

Result: _____

What activities **aggravate** their condition/pain? _____

_____

What activities **alleviate** their condition/pain? _____

_____

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Chiropractic History

Has your child ever been adjusted? Y N Doctor or Office's Name: _____

When? _____ Duration of care: _____

Reason for visit: _____ Result: _____

Technique used: _____ Last Adjustment: _____

Developmental History

Mom's Pregnancy: *check all that apply* If adopted and no details are known please check here _____

Chemical: ___Tobacco ___Alcohol ___Medications ___ Recreational drugs ___Special Diet

Physical/ Emotional: ___Falls/injuries ___Abuse (Physical, sexual, or emotional) ___Complications

Details of any checked: _____

_____

_____

_____

Birth: *check all that apply*

Third Trimester Presentation: _____ Vertex _____ Breech _____ Transverse _____ Face/Brow

Type of Birth: _____Vaginal _____ Forceps _____ Suction or Vacuum _____ Cesarean (ER or planned?)

Interventions: _____ Pitocin _____ Epidural _____ Ruptured Membranes _____ Episiotomy

Delivery Location: _____ OB/Midwife: _____

Other Details: _____

_____

_____

_____

_____

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Developmental History:

Breast Fed: Yes No How Long? _____ **Formula Fed:** _____Dairy _____ Soy How Long? _____

Breastfeeding issues / Reason formula fed?_____

Age when **solids** were introduced _____ Texture sensitivities? Yes No _____

Food Sensitivities _____

Allergies: Foods_____ Medicines _____ Other _____

Notes: _____

_____

_____

Physical, emotional, or sexual abuse? Yes No **Nightmares or Night Terrors?** Yes No

Notes: _____

_____

Crawled before walking? Yes No N/A **Shoulder or elbow dislocations?** Yes No

Played in a **hanging/bouncy swing** (Johnny Jump-Up)? Yes No Plays on a **trampoline**? Yes No

Can s/he currently: (mark all that apply) ___Sit Independently ___Crawl forward with opposite hand and knee
___ Stand Independently ___Walk Independently ___ Jump ___ Skip ___ Pinch ___Read ___ Write

Notes: _____

_____

_____

Mark all that apply for current **bowel/bladder** trends: ___ diapers all day and night ___ diaper/ pull-up at night only

___ teaching Elimination Communication ___ enuresis (bed-wetting) ___ bowel movement at least once daily

Females: Menarche (1st menstrual cycle) Yes No If yes, Age: _____ Cramps/PMS? Yes No

Notes: _____

_____

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Health History

Mark each they have had in the past or have now. Put "P" for past and "N" for now.

___ Ear Infections/Aches	___ Colds/Flu	___ Headaches	___ Poor Appetite
___ Sinus/Allergies	___ Asthma	___ Eczema/Skin Condition	___ Colic
___ Digestive problems	___ Changes in bowel/bladder	___ Reflux/Gassy	___ Stomach Aches
___ Concussion/Head injury	___ Neck or Back pain	___ Heart/Valve Issues	___ Seizures
___ Motor Integration Issues	___ Sensory Integration Issues	___ Learning Disabilities	___ADD/ADHD
___ Diabetes	___ Anemia	___ Bed Wetting	___ Hernia
___ Muscle pain	___ Growing pains	___ Arm problems	___ Leg problems
___ Poor posture	___ Scoliosis	___Walking trouble	___ Broken bones
___ Surgery	___ Sports Injury	___ Auto Accident	___ Scarlet Fever
___ Chicken Pox	___ Rubella	___ Measles	___ Rotavirus
___ Mumps	___ Rubeola	___ RSV	___ Diptheria
___ Fifth Disease/ Parovirus	___ Pertussis/Whooping Cough	___ Hand, foot, mouth	___ Croup

___ Other/ Family History: _____

Notes: _____

_____

Providers (Office and Doctor/provider name, last visit date and reason)_____

_____

_____

Vaccine History: ___Full CDC schedule ___ Selective schedule ___ Delayed, Full schedule ___ None

Why? _____

Medications (type and reason): _____

_____

Supplement (type and reason): _____

_____

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Child's Diet / Mom's Diet if Breastfeeding

	Daily/High	Weekly/Moderate	Monthly or less/Low	None/Never
Dairy (milk, yogurt, cheese)	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Gluten (flour, wheat, pasta)	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Soda/Energy Drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Water	_____	_____	_____	_____

Circle all that apply if mom is breastfeeding: caffeine, coffee, tea, alcohol, tobacco, medications of any type

Notes: _____

_____

_____

Household Habits

Do you **filter** your drinking/cooking/shower water? Yes No _____

Do you eat **organic foods**? Yes No _____

Do you use **organic health products** (soaps, shampoos, detergents)? Yes No _____

Do you **filter your air** at home? Yes No _____

Parent Signature: _____ **Date:** _____

Chiropractor/Intern Name: _____ Date: _____

Chiropractor/Intern Signature: _____

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Participant Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

Subluxation is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall healthy performance.

Subluxations are corrected and/or reduced by an ***adjustment***. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

Consent to evaluate a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

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HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Lotus of Life Chiropractic to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS:

_____ I give permission to Lotus of Life Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

_____ If Lotus of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

_____ I give permission to Lotus of Life Chiropractic to use my name on a welcome board, referral board, and birthday board.

_____ I give permission to Lotus of Life Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

_____ I give permission to Lotus of Life Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

_____ I give Lotus of Life Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Lotus of Life Chiropractic permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Lotus of Life Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

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 the Privacy Official of Lotus of Life Chiropractic. The written notice must contain the following information:
Your name and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Lotus of Life Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Lotus of Life Chiropractic will not refuse to provide treatment however, it will not be possible for Lotus of Life Chiropractic to contact me to schedule appointments or discuss my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

DOB:_____

Participant's Name (please print):_____

Participant's Signature:_____

Today's Date:_____

Name of Personal Representative (if someone is designated to act on your behalf/or for minor)

Parent or Personal Representative's name (please print):_____

Signature:_____

Today's Date:_____