FLOW CHIROPRACTIC

PEDIATRIC HEALTH RECORD

ABOUT YOUR CHILD

NAME:	
PARENT(S)/GUARDIAN(S) NAME:	
ADDRESS:	
CITY:	STATE AND ZIP CODE:
HOME PHONE:	PARENT'S CELL PHONE:
PARENT'S EMAIL ADDRESS:	
MAY WE LEAVE A MESSAGE AT HOME REGARDING YOUR CHILD'S CARE? ❑ YES ❑ NO, OR REGARDING YOUR APPOINTMENT? ❑ YES ❑ NO	
DATE OF BIRTH/AGE:	GENDER:
HOW DID YOU HEAR ABOUT OUR OFFICE?	

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IF THERE ARE SYMPTOMS, WHEN DID THEY FIRST BEGIN?
HOW DID THE PROBLEM START? SUDDENLY / GRADUALLY / POST-INJURY?
IS THE CONDITION: GETTING WORSE / IMPROVING / INTERMITTENT / CONSTANT / NOT SURE
WHAT MAKES THE PROBLEM BETTER?
WHAT MAKES THE PROBLEM WORSE?
DOES THIS CONDITION INTERFERE WITH: SLEEP / SCHOOL / DAILY ROUTINE / MEALS / SOCIAL OUTINGS / FAMILY EASE OR OTHER ACTIVITES? PLEASE EXPLAIN:
HAS YOUR CHILD EVER HAD A SIMILAR CONDITION? YES / NO PLEASE EXPLAIN:
HAS YOUR CHILD RECEIVED CARE FROM OTHER PROFESSIONALS FOR THIS CONCERN? YES / NO PLEASE TELL US WHO AND SPECIALTY:

BIRTH HISTORY

CHILD'S BIRTH WAS: HOME / BIRTHING CENTER / HOSPITAL
CHILD'S BIRTH WAS: A. NATURAL VAGINAL (NO MEDICATIONS/INTERVENTIONS) B. VAGINAL WITH INTERVENTIONS: INDUCTION / PAIN MEDS / EPIDURAL EPISOTOMY / VACUUM EXTRACTION / FORCEPS / OTHER C. C-SECTION: SCHEDULED / EMERGENCY DELIVERY: DID THE DOCTOR PULL OR TWIST THE BABY ? YES / NO / UNSURE
PLEASE LIST REASONS FOR ANY INTERVENTIONS / COMPLICATIONS:
CHILD'S BIRTH WEIGHT / HEIGHT: CHILD'S CURRENT WEIGHT / HEIGHT:
HOW LONG WAS LABOR? HOW LONG WAS THE DELIVERY?
DID MOTHER HAVE A DIFFICULT TIME CONCEIVING? IF YES, PLEASE EXPLAIN (INCLUDE TREATMENT):
ANY ILLNESS OF MOTHER DURING PREGNANCY? YES / NO IF YES, PLEASE EXPLAIN (INCLUDE TREATMENT):
LIST ANY MEDICATIONS , VACCINATIONS AND SUPPLEMENTS TAKEN DURING PREGNANCY (IF NOT LISTED ABOVE) AND FOR WHAT REASON:
WAS YOUR BABY EVER BREECH? YES/ NO/ UNSURE DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? YES / NO IF YES, HOW MANY_____
WAS THE MOTHER UNDER HIGH STRESS OR HAVE ANXIETY DURING THE PREGNANCY? YES / NO

GROWTH AND DEVELOPMENT

WAS YOUR CHILD ALERT AND RESPONSIVE WITHIN 12 HOURS OF DELIVERY? YES / NO IF NO, PLEASE EXPLAIN:
HOSPITALIZATION/SURGICAL HISTORY (PLEASE INCLUDE YEAR):
PLEASE LIST ANY MAJOR INJURIES, ACCIDENTS, FALLS, AND/OR FRACTURES:
IS/WAS YOUR CHILD BREASTFED? YES / NO IF YES, HOW LONG? ANY DIFFICULTY WITH BREASTFEEDING? YES / NO _____ DID YOUR CHILD HAVE COLIC? YES / NO WAS YOUR CHILD DIAGNOSED WITH ACID REFLUX? YES / NO
WAS FORMULA EVER INTRODUCED? AT WHAT AGE? WHAT TYPE?

FLOW CHIROPRACTIC

GROWTH AND DEVELOPMENT

WAS COW'S MILK INTRODUCED? YES/ NO AT WHAT AGE:_____

BEGAN SOLID FOODS AT AGE:

HAS YOUR CHILD RECEIVED ANY VACCINATIONS? ALL / MOST / SOME / NONE
NOTES:_____

REACTIONS: FEVER / SICKNESS / FUSSINESS / SEIZURES / LETHARGY / SWELLING
OTHER:_____

_____

HAS YOUR CHILD RECIVED ANY ANTIBIOTICS? YES / NO
IF YES, HOW MANY TIMES AND LIST REASON:

DOES YOUR CHILD HAVE ANY BEHAVIORAL PROBLEMS? YES / NO
IF YES, PLEASE EXPLAIN:

DOES /DID YOUR CHILD HAVE DIFFICULTY WITH BONDING? YES / NO
IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE NIGHT TERRORS, SLEEPWALKING OR DIFFICULTY SLEEPING? YES / NO
IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD SEEM TO BE DEVELOPING AT THE SAME RATE AS THEIR PEERS? YES / NO
IF NO, PLEASE EXPLAIN:

HOW WOULD YOU DESCRIBE YOUR CHILD'S DIET?

DOES YOUR CHILD HAVE REGULAR BOWEL/BLADDER MOVEMENTS? YES / NO

AVERAGE NUMBER OF HOURS OF TV/ELECTRONICS PER WEEK:

PLEASE LIST ANY ALLERGIES YOUR CHILD HAS:

YOUR CONCERNS

INSTRUCTIONS: *Please **circle** the health concerns or conditions your child may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.*

Runny Nose
Swollen Adenoids
Laryngitis/Strep/Sore Throat
Tonsillitis
Croup
Chronic Cough
Thyroid Issues
Poor Weight Regulation
Stiff Neck and Shoulders
Numbness Tingling
Hay Fever

C1
C2
C3
C4
C5
C6
C7

Headaches/Migraines
ADD/ADHD
Sensory/Spectrum Disorder
Insomnia
Reflux/GI Issues
Ear Infections/Aches
Vision Problems
Sinus Trouble/Allergies
Colic/Irritability
Anxiety
Balance/Coordination Issues
Acne/Eczema
Epilepsy/Seizure

T1
T2
T3
T4
T5
T6
T7

Asthma
Cough/Cold
Breathing Trouble
Heart Conditions
Chest Pain
Bronchitis
Pneumonia
Congestion
Chronic Colds/Flu
Reflux/GERD
Fever
Stomach Problems: Pain/ Indigestion/Ulcers
Liver Problems

Allergies
Immunity Issues: sickness
Hyperactivity
Kidney Troubles
Constipation/Gas Pains
Irritable Bowel Syndrome
Colitis
Abdominal Cramps
Diarrhea
Bladder Issues
Acne/Rash/Eczema
Fatigue

T8
T9
T10
T11
T12
L1
L2
L3

L4
L5
S
A
C
R
U
M

Constipation
Bedwetting/ accidents
Sciatic/Leg Pain
Weak Ankles/Arches
Difficult, Painful or Frequent Urination
Foot/Ankle/Knee Pain
Low Back Pain
Spinal Curvatures

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS/ SUPPLEMENTS

PLEASE LIST ANY VITAMINS/HERBS/HOMEOPATHIES YOUR CHILD IS TAKING:

_____
_____
_____
_____

PLEASE LIST ANY DRUGS OR MEDICATIONS YOUR CHILD IS TAKING:

_____
_____
_____
_____

GOALS FOR YOUR CARE

A LARGE NUMBER OF THE KIDS WE SEE IN OUR OFFICE ARE HERE FOR WELLNESS CARE. HOWEVER, PEOPLE CHOOSE TO SEE A PEDIATRIC CHIROPRACTOR FOR A VARIETY OF REASONS.

WHAT WOULD YOU LIKE TO GAIN FROM CHIROPRACTIC CARE?

_____
_____
_____
_____
_____

FLOW CHIROPRACTIC

FAMILY HISTORY REVIEW

Circle those involving immediate family and add identification: M=Mother, F=Father, S=Sibling, G=Grandparent			
Cancer, Type_____ M / F / S / G	Depression M / F / S / G	Diabetes M / F / S / G	Back Problems M / F / S / G
Heart Disease M / F / S / G	Liver Disease M / F / S / G	High Blood Pressure M / F / S / G	High Cholesterol M / F / S / G
Lung Problems M / F / S / G	Scoliosis M / F / S / G	Neck Problems M / F / S / G	Osteoporosis M / F / S / G
Seizures M / F / S / G	Osteoarthritis M / F / S / G	Rheumatoid Arthritis M / F / S / G	Other _____

AUTHORIZATION FOR CARE OF A MINOR

I, _____hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child, to work with their condition through the use of adjustments and procedures the doctor deems appropriate.

TERMS OF ACCEPTANCE

It is essential to understand that the patient and the Doctor have the same objective. To prevent any confusion, it is important to understand that chiropractic has one main goal. Our only objective is to eliminate an interference to the expression of the body's innate wisdom by providing specific adjustments to correct vertebral subluxations. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of an evaluation, we encounter non-chiropractic findings, we will advise you. Regardless of what diagnoses you may have been given by other professionals we do not offer to treat it, nor will we offer advice regarding their treatment prescribed.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office and understand that FLOW Chiropractic does not bill to insurance for reimbursement. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:

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.

PARENT OR GUARDIAN AURTHORIZING CARE SIGNATURE	RELATIONSHIP TO PATIENT:
PARENT OR GUARDIAN AUTHORIZING CARE NAME PRINTED	DATE:

FLOW Chiropractic
325 E 100 N Ste B
Lehi, UT 84043
(385) 389-6200

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. You have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I understand that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____