INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine

2114 Schofield Avenue, Weston, WI 54476

PEDIATRIC HEALTH HISTORY

(Ages 6 & under)

☐ New Patient
☐ Reactivate (1 yr)

Please fill out this form as completely as possible. In order for us to provide the best care, it is important that we get a complete picture of your overall health. In addition, the U.S. Government requires us to collect certain data including your social security number, race/ethnicity, and other demographic information as requested on this form. Questions? ***Call 715-355-4224.***

ABOUT YOUR CHILD:		Today's Date:	
Legal Name (*First, Middle, Last*):		Birthdate:	Age:
Social Security #:	Sex: ☐ Male ☐ Female	Ethnicity: ☐ Non-Hispanic ☐ Hispanic	

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Primary Medical Doctor:	Medical Doctor Clinic & City:

How did you hear about our clinic:

PARENT/GUARDIAN: ☐ Biological Mother ☐ Biological Father ☐ Legal Guardian ☐ Foster Parent ☐ Other:_____

Legal Name (*First, Middle, Last*):	Date of Birth:
Street Address:	Home Phone: ☐ Preferred
City / State / Zip:	Cell Phone: ☐ Preferred
Social Security #:	Work Phone: ☐ Preferred
Driver's License #:	Email:
Occupation:	Employer:

PARENT/GUARDIAN: ☐ Biological Mother ☐ Biological Father ☐ Legal Guardian ☐ Foster Parent ☐ Other:_____

Legal Name (*First, Middle, Last*):	Date of Birth:
Street Address (*If different):*	Home Phone: ☐ Preferred
City / State / Zip:	Cell Phone: ☐ Preferred
Social Security #:	Work Phone: ☐ Preferred
Driver's License #:	Email:
Occupation:	Employer:

Who is responsible for medical financial obligations of this child?

Marital Status of Legal Guardian(s): ☐ Married ☐ Single ☐ Live-in Partner ☐ Separated ☐ Divorced ☐ Widowed

If Divorced: ☐ Joint Custody ☐ Mother Sole Custody ☐ Father Sole Custody ☐ Legal Documents Provided (see below)
If patient is in the care of someone other than a biological parent, please provide legal documentation of guardianship/custody.

INSURANCE COVERAGE Do you have Insurance? ☐ No ☐ Yes If yes, please provide card for us to photocopy.

	Primary Insurance Provider	Secondary Insurance Provider
Insurance Company:		
Phone Number:		
Policy / Subscriber ID Number:		
Group Number:		
Policyholder Name:	☐ Check if different address	☐ Check if different address
Policyholder Relationship to Child:		
Policyholder Date of Birth:		

PRESENTING ILLNESS / CHIEF COMPLAINT

Describe the condition/symptoms for which you're seeking care:

When did it begin: Since then, the problem has gotten: ☐ Better ☐ Worse ☐ Stayed the same

How did it occur:

Do symptoms change throughout the day? Are they constant? Do they come and go?

How many times have you had this condition/these symptoms before? ☐ 0-3 times ☐ 4 or more times

Has your child seen anyone else for this condition? ☐ Yes ☐ No If yes, when?

Name of doctor/clinic: Clinic location:

Diagnosis: Treatment results:

List any visible bumps, scrapes, cuts, etc. on your child:

YES	NO	
☐	☐	Has there been a change in eating habits? If yes, describe:
☐	☐	Has there been a change in sleeping habits? If yes, describe:
		How many hours sleep does your child get on an average night?
☐	☐	Does your child cry if you attempt to change his/her sleeping position?
☐	☐	Does your child wake up and cry frequently at night? If yes, describe:
☐	☐	Does your child have a fever of unknown origin?
☐	☐	Does your child have a loss of appetite or other eating disorder? If yes, describe:
☐	☐	Has there been a recent change in your child's bathroom habits? If yes, describe:
		How many bowel movements does your child have per day? Is he/she bedwetting? ☐ Yes ☐ No

FOR CHILDREN AGES 2 & UNDER: Child's delivery: ☐ Vaginal ☐ Cesarean

Position at birth: ☐ Head down ☐ Breech ☐ Shoulder down Was there more than one baby? ☐ Yes ☐ No

Were extraction aids used during delivery (e.g. forceps, suction) ☐ Yes ☐ No

Was labor prolonged? ☐ Yes ☐ No How long was labor?

MEDICAL HISTORY

Has your child ever seen a chiropractor before? ☐ Yes ☐ No If yes, when?

For what condition was your child treated?

Name of doctor/clinic: Clinic location:

Has your child ever been in an automobile accident? ☐ Yes ☐ No If yes, when?

Describe any injuries: Describe treatment:

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			

List allergies ☐ None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

FAMILY MEDICAL HISTORY

List medical conditions experienced by your child and immediate family members in the grid below.

	This Child	**Mother**	**Father**	**Sister**	**Brother**
Example:		*Asthma*	*Healthy*	*Ear Infections*	*ADHD*
Eyes (glasses/contacts, cataracts, glaucoma, blindness, etc.)					
Ear, Nose, Mouth, Throat (hearing loss, ear infections, sinus issues, allergies, etc.)					
Cardiovascular (heart attack, cholesterol, high BP, congestive heart failure, pacemaker, etc.)					
Respiratory (lungs, breathing, asthma, COPD, etc.)					
Neurological (nerve issues, weakness, numbness, etc.)					
Endocrine (thyroid, hormonal imbalances, liver, etc.)					
Gastrointestinal (acid reflux, ulcers, IBS, gall bladder, etc.)					
Genitourinary (male/female reproductive, kidney, bladder, etc.)					
Skin (rashes, skin cancer, dryness, psoriasis, eczema, hair, etc.)					
Psychiatric (anxiety, depression, bipolar, ADD, ADHD, etc.)					
Other (please describe)					

If your child is currently receiving treatment for a medical condition, please describe:

Is there anything else you think we should know?

I certify that the above statements are true and complete to the best of my knowledge. I authorize the doctor to examine and treat my child through the use of chiropractic care, and I give authority for these procedures to be performed.

Parent/Guardian Signature:_____ Date: _____

Staff Initials:

INFORMED CONSENT

While chiropractic care is remarkably safe, like any health care treatment, it does have some risks. It is your right as a patient to be informed of the potential risks of care so that you are fully informed in consenting to treatment.

The nature of the chiropractic adjustment - The primary treatment used by Doctors of Chiropractic is called spinal manipulative therapy. Your doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment - As a part of the analysis, examination, and treatment, a variety of tests and therapies may be used in your care including: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies (x-rays), palpation, orthopedic testing, postural analysis, basic neurological testing, hot/cold therapy, vital signs, EMS, ultrasound, spinal decompression therapy, and/or high intensity laser therapy.

The material risks inherent in chiropractic adjustment - As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

The probability of those risks occurring - Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor will check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. *Statistically speaking, the risk of stroke from unknown causes in the general population actually exceeds the risk of stroke following a chiropractic adjustment*. The other complications are also generally described as rare.

Results - As with any health care option, we cannot guarantee any particular results from our chiropractic treatment. 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 qualified health care provider.

The availability and nature of other treatment options - Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; surgery. There are risks and benefits with each of these options, and you may wish to discuss these risks and benefits with your primary medical physician.

The risks and dangers attendant to remaining untreated - Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Having carefully read the above, I hereby give my informed consent to have the doctors of Innovative Health administer chiropractic care.

Patient Name (printed)

X

Parent/Guardian/Legal Representative Signature

Date