Bettendorf
Chiropractic Wellness Center

Pediatric New Patient Health History Form

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Patient Data

First Name:_____ Last Name: _____ Today's Date: _____

Address: _____ City: _____ State:_____ Zip:_____

Mother's Name: _____ Mother's Employer: _____

Father's Name: _____ Father's Employer: _____

Mother's Phone: _____ Father's Phone: _____

Birth Date: _____ Sex: _____F _____ M

How were you referred? _____

The Birth

Age of Patient: _____ yrs _____ months

Birth Weight: _____ Birth Length: _____Current Weight: _____ Current Length:_____

Was the Birth: ____ Normal _____ Breech _____ Cesarean _____Home Birth _____ Vacuum Extraction _____ Forceps

Where was the Birth: _____

Any pregnancy problems: _____

_____

Congenital (Birth) Defects/Abnormalities? _____

_____

Was there Presence at Birth: _____ Meconium ____ Cyanosis(Blue) ____ Jaundice (yellow)

Pediatrician/Family MD _____

Obstetrician/Midwife _____

Date and Purpose of Last MD Visit: _____

Has this Child Been Treated for an Emergency? ____ Yes ____ No Describe_____

_____

Surgeries _____

Traumas: _____

Medications and Vitamins: _____

Accidents (Even Minor: _____

Has the child been hospitalized: _____

Has this child ever been under chiropractic care? NO ____ YES ____

In order to provide you the best possible wellness care, please complete this form.
All information is strictly CONFIDENTIAL.

Has this Child Ever Suffered From:	
____ Allergies	____ Heart Troubles
____ Anemia	____ High Blood Pressure
____ Arthritis	____ Hyperactivity
____ Asthma	____ Irregular Heart Beat
____ Arm Problems	____ Joint Problems
____ Backaches	____ Leg Problems
____ Bed Wetting	____ Muscle Jerking
____ Bronchitis	____ Neck Problems
____ Behavior Problems	____ Neuritis
____ Cancer	____ Orthopedic Problem
____ Constipation	____ Paralysis
____ Convulsions	____ Poor Appetite
____ Diabetes	____ Rheumatic Fever
____ Digestion Problems	____ Ruptures/Hernias
____ Dizziness	____ Sinus Trouble
____ Earaches	____ Sleep problems
____ Fainting	____ Spinal Curvatures
____ "Growing Pains"	Other
____ Headaches	_____

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Family Member: (ie.mother, father)	Condition:
_____	_____
_____	_____
_____	_____
_____	_____

I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to the rendering physician for services rendered.

Signature: _____ Date: _____

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Informed Consent for Care

You are the decision maker for the health care of your child. This informed consent involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, the potential effect on your child's health if you choose not to receive the care and any of the fees for the services being provided to your child by Bettendorf Chiropractic Wellness Center.

Chiropractic care involves what is known as a chiropractic adjustment and possible additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing pain, swelling and inflammation in a joint, and improving neurological function and overall well-being. We may conduct chiropractic, physiotherapy, acupuncture, diagnostic or examination procedures if indicated that will be carefully performed but may be uncomfortable.

It is important you and your child understand, as with any health care approach, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burn and/or scarring from electrical stim or cold therapies, broken bones, disc injuries, dislocations, strains and sprains and strokes.

With respect to stroke, 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 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 dissection have been associated with over 72 everyday activities such as sneezing and driving. Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients, who experience the condition often, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1 million to 1 in 2 million cervical adjustments.

It is also important that you understand that there are treatment options available for your child's condition other than chiropractic procedures. Likely, you have tried many of these approaches already and have the right to a second opinion about your child's circumstances and health care as you see fit.

I understand that if my child is accepted as a patient by Bettendorf Chiropractic Wellness Center, I have read, or have had read to me, the above consent. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to my child and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment for my child, any fees for professional services rendered to my child will be immediately due and payable. I am authorizing them to proceed with any treatment that may be necessary for my child. I appreciate 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 for my child is deemed appropriate for any circumstance for which I seek chiropractic care for my child from Bettendorf Chiropractic Wellness Center.

I hereby authorize Gina M. Lehman, DC, FASA and Keeli L. Farley, DC and whomever they may designate as an assistant to examine and administer treatments as deemed necessary to my child, _____.

Printed name of person authorizing treatment: _____

Signature: _____

Date: _____ Relationship to Child: _____

You have been offered a copy of our financial policy. _____(initial)

You have been offered a copy of our HIPAA privacy policy. _____(initial)

May we confirm your appointments by email, text or phone? (circle one) YES NO

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