T, C/D, E, X

Start Time:

Ins. & Ded.

Platinum No.

PDR Date:

Guest:

PD: Y N

RESTORATION CHIROPRACTIC

Pediatric Health Application

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Guardian(s) Name:_____ Relationship:_____

Phone : _____ Email:_____

Preferred Contact: Email / Text Message / Phone Call Weight: _____ Height: _____

Number of Siblings: _____ Names, Ages, and Gender_____

Whom may we thank for referring you?_____

List The Health Concerns That Brought You Into This Office

Health Concern: List according to severity. ↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	_____
Second:_____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

_____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Migraines
___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems	___Diabetes
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___Seizures	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___Scoliosis	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ Growing pains
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other:_____

RESTORATION

CHIROPRACTIC

Pregnancy Information:

How was your pregnancy?_____

Any pregnancy complications?_____

Did you take any medication during your pregnancy?_____

Other information: _____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section

_____

Induced? Yes/No Explain:

_____

Medications during delivery?_____

Other information: _____

Post Birth Information:

Birth Weight:_____ Birth Length: _____

Breast Fed: Yes/No How long?_____ Formula Fed Yes/No How Long?_____

Introduced Solid Foods at _____ Months

Food Allergies or Intolerances:_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____ Total Lifetime _____

Present prescription drugs/ dosage?_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years: _____

Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

RESTORATION

CHIROPRACTIC

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Neck Shoulder _____ Worst possible pain

0 1 2 3 4 (5) 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Holding Head Up	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Tummy Time	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Nursing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sitting Up	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Crawling	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Standing Alone	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking Alone	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

ACTIVITY	CURRENT ACTIVITY LEVEL	GOAL ACTIVITY LEVEL
Example: Tummy Time	Less than 2 minutes	5 minutes

RESTORATION

CHIROPRACTIC

For A Minor/Child, Please Fill Out And Sign Below

Written Consent For A Child

Name of practice member who is a minor/child: _____ _____

I authorize Dr. Jake Schumann and any and all Restoration 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 Restoration Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Restoration Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____