



# Child's Case History

Please Print

DATE: \_\_\_\_\_

## Patient Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Parent #1 Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Parent #2 Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Sibling's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F

Sibling's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F

Sibling's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F

## Family Medical History

Please check below if any blood relatives to the patient had any of the following illnesses and mark accordingly by noting: M (mother); F (father); PGM (paternal grandmother); MGM (maternal grandmother); PGF; or MGF.

- Allergy, Asthma or Eczema
- Cancer
- Diabetes or Low Blood Sugar
- Heart Trouble
- High Blood Pressure/Stroke
- Mental Illness/Nervous Disorders
- Scoliosis
- Ulcer
- Kidney or Liver Disease
- Other (Explain \_\_\_\_\_)

## Mother's History

### I. Pregnancy

Please check any area that applied to the patient's mother during her pregnancy:

- Chiropractic Care
- Prenatal Classes/Care
- Exercise
- Smoked
- Any Diagnosed Illnesses \_\_\_\_\_
- Hospitalization
- Immunization
- Premature Contractions

Alcohol  Bleeding  
 Caffeine  Excessive Increase/Decrease in Weight  
 Recreational Drugs  Physical Injury  
 Medications \_\_\_\_\_  Complications \_\_\_\_\_  
 Vitamins/Minerals \_\_\_\_\_  Back/Spine Pain  
 Allergic Reactions \_\_\_\_\_  Other Pain \_\_\_\_\_  
 Attitude (majority of time) [  Happy  Depressed ]

**ii. Labor & Delivery**

How many weeks duration was the pregnancy? \_\_\_\_\_ How long was your labor? \_\_\_\_\_

Would you say it was easy, hard, or very hard?  E  H  VH

Fetal Monitor Used  Medications (Epidural/Spinal Block)  
 Artificially Induced  Complications \_\_\_\_\_

How did you deliver this child: on your back, all fours, squatting, sitting up in a birthing chair, C-section, other?

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Were the following involved?  Forceps  Vacuum Extraction  Other \_\_\_\_\_

**Child's History**

Do you remember the APGAR score?  Y  N  
 If so, what was it? \_\_\_\_\_

Please check any problems the patient had at birth:

Breathing  Coloring  Crying  Choking  Nursing  
 Sleeping  Jaundice  Other: \_\_\_\_\_

Please check if any item(s) applied to the patient at birth:

Medication  Surgery  Artificial Feeding  Silver Nitrate  Vitamin K  
 Circumcision  Other: \_\_\_\_\_

Please Check any problems the patient has had since birth:

Ear Infections  Colds  Mucus/Sinus trouble  Colic  Falls  
 Accidents (automobile)  Allergies  Asthma  Other \_\_\_\_\_

Did/Does s/he crawl?  Y  N How long? \_\_\_\_\_

Did/Does s/he use a walker?  Y  N How long? \_\_\_\_\_

**III. Nutrition**

Please check if the patient has received any of the following items:

Breast Milk  Sweets  
 Commercial Formula  Juice: Fruit  
 Cow's Milk  Juice: Vegetable

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\_\_\_\_\_ Goat's Milk                      \_\_\_\_\_ Soda  
\_\_\_\_\_ Other Milk                      \_\_\_\_\_ Vitamins  
\_\_\_\_\_ Solid Foods                      \_\_\_\_\_ Medications  
\_\_\_\_\_ Other: \_\_\_\_\_

**IV. Medical History**

Please list any immunizations the patient has received along with the approximate date/age it was received and any reactions observed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications (past or present): \_\_\_\_\_  
\_\_\_\_\_

List any surgeries: \_\_\_\_\_  
\_\_\_\_\_

Please list any pre-diagnosed conditions or serious illnesses. Include any serious mental or physical traumas. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name & phone # of pediatrician and date of last examination. \_\_\_\_\_  
\_\_\_\_\_

**V. General System Review**

1. Has your child ever been unconscious or had a convulsion? \_\_\_\_\_  
\_\_\_\_\_

2. Any problems with the eyes, including vision? \_\_\_\_\_  
\_\_\_\_\_

3. Has your child ever been cyanotic (turned blue)? Does s/he tolerate exercise? \_\_\_\_\_  
\_\_\_\_\_

4. Any recurring problem with vomiting, diarrhea, constipation, or stomach pain? \_\_\_\_\_  
\_\_\_\_\_

5. Do the stools look or smell abnormal? \_\_\_\_\_

6. Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance of urine? \_\_\_\_\_  
\_\_\_\_\_

7. Does your child complain of any extremity or back pain? Do you notice a limp or unusual gait pattern? \_\_\_\_\_  
\_\_\_\_\_

8. Any skin, hair, nail, or tooth problems? \_\_\_\_\_  
\_\_\_\_\_

9. Any allergies, eczema, hay fever, hives, asthma, or drug reactions? \_\_\_\_\_  
\_\_\_\_\_

10. What is your child's general demeanor (fussy, alert, happy, etc.)? \_\_\_\_\_  
\_\_\_\_\_

11. Anything else you may have noticed about your child you think is unusual? \_\_\_\_\_

\_\_\_\_\_

12. Any other problems? \_\_\_\_\_

\_\_\_\_\_

### **Authorization**

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Mother, Father or Legal Guardian

Relationship to Patient \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of High Point Chiropractic's Notice of Privacy Practices for Protected Health Information, and I have been told that a copy is available at the front desk at any time.

\_\_\_\_\_ Date

Patient Signature

## PATIENT PREGNANCY DISCLAIMER (FEMALES ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time,

\_\_\_\_\_ I am sure that I am not pregnant.

\_\_\_\_\_ It is possible that I could be pregnant.

\_\_\_\_\_ I am pregnant.

\_\_\_\_\_ Date

Patient Signature

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

## INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are moving of bones with the doctor's hands or with the use of a machine, table, or instrument. Frequently adjustments created a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

**Stroke:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust-atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustment may also potentially be related to vertebral artery strokes, but no one is certain. One of the most recent studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**Disc Herniations:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. This result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**Rib Fractures:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

**Physical Therapy Burns:** Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soreness:** It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise cure for any symptoms, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments and resultant nerve interference).
2. Adjustment of the spine for the purpose of correcting vertebral subluxations.
3. Education and encouragement of our patients/practice members to become aware of and responsible to their well-being.
4. Empowerment of our patient/practice members as to the inherent healing capabilities of the human body. Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I understand the practice of chiropractic as outlined, I am aware of the risks as outlined above, and wish to receive care at HIGH POINT CHIROPRACTIC for myself/my family.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Provider Representative      Printed

\_\_\_\_\_  
Date

Witnessing signing of:     Authorization to treat     Privacy Notice     Pregnancy Disclaimer     Informed Consent