ARMONIA
CHIROPRACTIC

Pediatric New Practice Member Application

Name _____ Date of Birth _____ /_____ /_____ Age _____ Male / Female
Address _____ City _____ State _____ Zip _____
Guardian(s) Name _____ Relationship _____
Phone Number _____ Weight _____ Height _____
Who may we thank for referring you? _____

List the Health Concerns That Brings Your Child into Our Office

	Health Concerns (List according to severity)	Rate the severity of stress this causes in your life (0=none, 10=unbearable)	When did this Problem begin?	Have you had this Problem before?	Are your 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	___ Stomach Problems	___ 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	___ Difficulty Breathing
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ Growing pains
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Torticollis

Other:_____

Pregnancy + Fertility History:

Any fertility issues? □ Yes □ No If yes, explain: _____

Did mother smoke? □ Yes □ No If yes, how many times per week? _____

Did mother drink? □ Yes □ No If yes, how many times per week? _____

Did mother exercise? □ Yes □ No If yes, explain: _____

Was mother ill? □ Yes □ No If yes, explain: _____

Any ultrasounds? □ Yes □ No If yes, how many? _____

Please explain any notable episodes of mental or physical stress during the pregnancy:

_____

Please explain any other notable remarks about your conception or pregnancy with your child:

_____

Labor + Delivery History:

Child's birth was: Natural Vaginal Birth Scheduled C-Section Emergency C-Section

Location of birth: Home Birth Center Hospital Other: _____ At how many weeks was your child born? _____ Circle any applicable interventions or complications:

Breech Forceps Vacuum Extraction Induction Pain Meds Epidural Pitocin Episiotomy

Other information: _____

Birth Weight: _____ lbs. _____ oz. Birth Length: _____ in.

APGAR Score at Birth: _____ APGAR Score After 5 Minutes: _____

Growth + Development History:

Breastfed: □ Yes □ No How long? _____ Formula fed □ Yes □ No How long? _____

Difficulty breast feeding: □ Yes □ No Introduced solid foods at _____ months

Did / does your child suffer from colic, reflux, or constipation as an infant? □ Yes □ No

If yes, please explain: _____

Did / does your child frequently arch their neck / back, feel stiff, or bang their head? □ Yes □ No

If yes, please explain: _____

Have you chosen to vaccinate your child? □ No □ Yes, on a delayed schedule □ Yes, on schedule

If yes, please list any vaccine reactions: _____

Has your child received any antibiotics? □ Yes □ No If yes, how many times? _____

If yes, for what reasons? _____

Food allergies / intolerances and when they began: _____

List all hospitalizations and surgical operations, including the year:

_____

List any major accidents, falls, head injuries, or fractured bones your child has sustained in their lifetime, including the year:

_____

Night terrors or difficulty sleeping? □ Yes □ No If yes, explain: _____

Behavioral, social, or emotional issues? □ Yes □ No If yes, explain: _____

How would you describe your child's diet? □ Mostly whole, organic foods □ High amounts of processed foods □ Average

At what age did your child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____

Vocalize: _____ Teethe: _____ Sit alone: _____ Crawl: _____ Walk: _____

Activities of Life (Ages 0-2 years)

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

Activities of Life (Ages 3-12 years)

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

ACTIVITY:	EFFECT:			
Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walk	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Run	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercise / Play	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Play Sports	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ 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

List your Top 3 Health Goals for your child:

1. _____
2. _____
3. _____

What are you hoping to gain from chiropractic care? □ Resolve existing condition □ Overall wellness □ Both

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked, 0=no pain and 10=unbearable. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

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 BEST?

   0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST?

   0 1 2 3 4 5 6 7 8 9 10

Practice Member Name (child): _____ Date: _____

For A Minor/Child Guardian, Please Fill Out and Sign Below

Written Consent for a Child

Name of practice member who is a minor/child: _____ I authorize Dr. Todd & Dr. Harley and any and all Armonia 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 Armonia 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 Armonia 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: _____