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: _____