Dr. Kristen Ude
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WELCOME!

Child's Information:

Name:_____ Date of Birth:_____ Age:_____

Approx. Weight and Height _____

Address_____ Apt #_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Responsible Party (Parent(s)) Information: PLEASE PRINT

Mother:_____ Father:_____

Mother Phone: _____ Father Phone: _____

Mom Birthdate: ____/____/____ Dad Birthdate: _____/____/____

Are the parents of this child: □ Single □ Married □ Divorced

Home Address if different from above:_____

City_____ State_____ Zip_____

Work Phone_____ Ext._____

E-mail Address _____

Employer Name_____ Occupation_____

Whom may we THANK for referring you to us?_____

What is the reason for this visit?

Please list any health conditions your child has been diagnosed with:

Medications your child currently takes:

History of antibiotic use?

Supplements, herbs, remedies your child is currently taking:

Hospital surgeries/procedures your child has had:

Lifestyle

Does your child consume the following (please circle):

Soda	none	<2 cans per day	>2 cans per day
Sweets	none	<twice/day	>twice/day
White flour	none	<twice/day	>twice/day
Milk/Dairy	none	<twice/day	>twice/day
Juice	none	<twice/day	>twice/day
Meat/fish	none	<twice/day	>twice/day

How much water does your child drink each day:_____

Smokers in the home? Yes No

Consistent physical activity? Yes No

Please list regular exercises or sports:_____

History:

Colic as an infant? Yes No

How was your child fed as an infant? Breast Bottle

If bottle, what kind of formula?_____

Has your child had respiratory infections? Yes No

How often?_____

Does your child complain of neck or back pain? Yes No

Please explain:_____

Does your child complain of arm or leg pain? Yes No

Please explain:_____

Headaches? Yes No

Has your child had ear infections? Yes No

First occurrence and frequency:_____

Do they occur in same ear? Yes No Which ear? Left Right Both

Has your child been vaccinated? Yes No Recently? Yes No

Please describe any vaccine reactions:_____

Sleep Habits:

Does your child sleep: Well - Trouble falling asleep - Trouble staying asleep

Does your child wake up tired: Yes No

How many hours does your child sleep on average per night? _____

Does your child take naps? Yes No

Does your child have nightmares? No Sometimes Often

For Cycling Females Only:

Age of first period:_____

Is your child using any methods of birth control? Yes No

If yes, what kind? Oral Pill Injected Patch Ring

How long has she been using birth control?_____

Any symptoms while on birth control? (yeast infections, heavy/light bleeding, moddiness, weight gain, sweet cravings, palpitations, fatigue)_____

_____

Is menstrual cycle regular? Yes No

_____

Excessive cramping or bleeding? Yes No

SYMPTOM CHECKLIST FOR YOUNG CHILDREN

Point Scale

0 - *Never* or *almost never* has the symptom
1 - *Occasionally* has symptoms
2 - *Frequently* has symptoms

HEAD	_____	Headaches	
	_____	Difficulty falling asleep	
	_____	Wakes up during the night	Total _____
EYES	_____	Watery or itchy eyes	
	_____	Dark circles under eyes	
	_____	Bags under eyes	
	_____	Swollen eyelids	Total _____
EARS	_____	Reddening of ears	
	_____	Itchy ears	
	_____	Earaches/Ear infections (circle which apply)	
	_____	Drainage from ear	
	_____	Hearing loss	
	_____	Frequent pulling on ears	Total _____
NOSE	_____	Runny nose	
	_____	Stuffy nose	
	_____	Sneezing	
	_____	"Allergic Salute" (rubs, itches, wipes nose frequently with hands)	Total _____
MOUTH/THROAT	_____	Swollen or red lips	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or sore or discolored tongue	
	_____	Swollen or sore gums or lips	
	_____	Canker sores	Total _____
SKIN	_____	Easy bruising	
	_____	Hives	
	_____	Rash	
	_____	Dry or flaky skin	
	_____	Flushing	
	_____	Cold hands or feet	
	_____	Eczema	Total _____
LUNGS	_____	Coughing	
	_____	Sneezing	
	_____	Difficulty breathing	
	_____	Wheezing	Total _____

DIGESTIVE TRACT	_____	Nausea	
	_____	Vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching	
	_____	Passing gas (flatulence)	
	_____	Heartburn	
	_____	Tummy ache	
	_____	Poor appetite	
	_____	Refusal to eat	Total _____
JOINTS/MUSCLE	_____	Coordination problems	
	_____	Pain in muscles (e.g., leg ache)	
	_____	Pain in joints (e.g., knee ache)	Total _____
ENERGY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	
	_____	Sleeping problems	Total _____
MIND/EMOTIONS	_____	Inattentiveness or poor concentration	
	_____	Mood swings	
	_____	Anxiety, nervousness	
	_____	Fear	
	_____	Anger	
	_____	Irritability	
	_____	Aggressiveness (e.g. hitting, kicking, biting)	
	_____	Crying or weepiness	
	_____	Tantrums	
	_____	Hyperactivity	Total _____
OTHER	_____	Frequent urination	
	_____	Itching of anus or genitals	
	_____	Bed wetting	
	_____	Wetting or soiling of clothes	
			Total _____
GRAND TOTAL			TOTAL _____

CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to myself while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications may include but may not be limited to: fractures, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications. The chiropractic profession has relied on comprehensive research to determine the level of risk associated with chiropractic neck manipulation and there is negligible evidence to support a causal relationship between cervical manipulation and vertebral artery dissection, which can lead to stroke. In fact, scientific studies have shown that neck manipulation (or chiropractic cervical adjustment) is safe, effective and appropriate for patients with common forms of neck pain and headache. An estimate of the odds of suffering a serious complication from a chiropractic neck adjustment are 1 in 5 million cervical manipulations. I do not expect the doctor to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I understand that I will have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Integrated Chiropractic Wellness, PLLC
Dr. Kristen Ude
1600 W. 38th Street Suite 412
Austin, TX 78731

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

[Consent to evaluate and adjust a minor child.]

I, _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

SIGNATURE _____ DATE _____