Whom may we thank for referring you to this office _____

PEDIATRIC APPLICATION FOR CARE AT RESTORE HEALTH

PATIENT DEMOGRAPHICS

Child's Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____State: _____ Zip: _____

E-mail Address: _____ Mobile Phone: _____ Call or Text: _____

Health Insurance: ☐ Yes ☐ No Policy Holder's Name and DOB:_____

Parent's Name(s): _____ Birth Date: _____-_____-_____ Phone:_____

Name & Number of Emergency Contact: _____Relationship: _____

	PRIMARY COMPLAINT	SECOND COMPLAINT	THIRD COMPLAINT	FOURTH COMPLAINT
Area of Complaint:				
What caused it?				
When did it start?				
Circle Frequency*	0-25% 26-50% 51-75% 76-100%	0-25% 26-50% 51-75% 76-100%	0-25% 26-50% 51-75% 76-100%	0-25% 26-50% 51-75% 76-100%
*Frequency Scale:	Occasional: 0-25% →	Intermittent:26-50% →	Frequent:51-75% →	Constant:76-100%
Current Pain Level (0-10)				
Average Pain Level (0-10)				
When is it at its **Worst?**	AM Mid-Day PM	AM Mid-Day PM	AM Mid-Day PM	AM Mid-Day PM
When is it at its **Best?**	AM Mid-Day PM	AM Mid-Day PM	AM Mid-Day PM	AM Mid-Day PM
Previous Treatment Received:				
Treatment Length:				
Treatment Results:				

Name of Previous Chiropractor: _____ □ **N/A**

PLEASE MARK BODY USING THE FOLLOWING

Using patient diagram with the following letters to describe your symptoms:

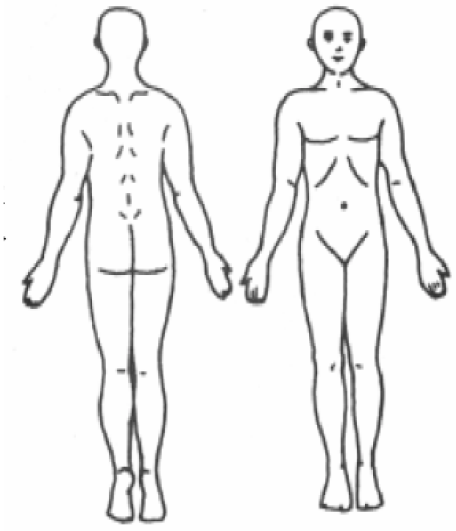
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching
N = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

TODAY'S DATE: _____



Please check boxes for any current or past history of conditions/problems with any of the following:

☐ADD/ADHD ☐Allergies ☐Asthma ☐Blurred Vision ☐Chest Pain ☐Digestive ☐Gallbladder ☐Epilepsy ☐Menstrual ☐Balance ☐Bed Wetting ☐Convulsions ☐Depression ☐Dizziness ☐Breathing ☐Heartburn ☐Hearing Loss ☐Fainting ☐Foot/Knee Pain ☐Hip Pain ☐High Blood Pressure ☐High Cholesterol ☐Shoulder Pain ☐Hand/Wrist Pain ☐Liver Issues ☐Low Back Pain ☐Mid Back Pain ☐Neck Pain ☐Scoliosis ☐Ringing in Ears ☐Sinus Pain ☐Sleeping ☐Numbness/Tingling Arms/Hands ☐Numbness/Tingling Legs/feet ☐Swollen/Painful Joints ☐Ulcers ☐Kidney ☐Mood Disorders ☐Anxiety ☐Lung Issues ☐Skin Issues ☐Hepatitis (A,B,C) ☐Eating Disorder ☐Heart Problem ☐Constipation ☐Pain Coughing/Sneezing ☐Menopausal ☐Learning Disability ☐Bi-Polar Disorder ☐Developmental Delays ☐Frequent Colds/Immune ☐Double Vision ☐Low Blood Pressure ☐Headaches ☐Tremors/Convulsions ☐TMJ/Jaw Pain

_____

Prenatal History:

How many weeks at time of birth:_____ Any complications during pregnancy:_____

Birth Weight: _____ Birth Length:_____ Induced into Labor: ☐ Yes ☐ No

Epidural: ☐ Yes ☐ No Ultrasounds during Pregnancy: ☐ Yes ☐ No Medications during: ☐ Yes ☐ No

Location of Birth: Birth Center Home Hospital Birth Interventions: Forceps Vacuum Caesarian Section

If C-section, was it? Planned or Emergency Any Known Genetic Disorders: ☐ No ☐ Yes:_____

Vaccinated: ☐ Yes ☐ No If Yes, Any adverse reactions:_____

PLEASE identify ANY PAST CONDITIONS you feel may be contributing to your present problem:

	WHEN	CARE RECEIVED	RESULTS
INJURIES →			
SURGERIES →			
DISEASES →			
ANYTHING NOT LISTED PREVIOUSLY →			

SOCIAL HISTORY

Does Your Child: Eat Healthy Foods: ☐ Yes ☐ No **Drink Water:** ☐ Yes ☐ No

Exercise: ☐ Yes ☐ No If yes, how frequently: ☐ Minimal ☐ Moderate ☐ Heavy **Sports Played**:_____

Take any Vitamins: ☐ Yes ☐ No If yes, please list:_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other: _____

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ❑Yes: _____

I hereby authorize payment to be made directly to RESTORE HEALTH for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to RESTORE HEALTH for all services I receive at this office.

_____ _____ - _____ - _____

Parent or Authorized Guardian's Signature **Date Completed**

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Restore Health have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Parent or Authorized Guardian's Signature **Date**

X-RAYS/ Imaging Studies 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.

PLEASE NOTE: X-Rays are used in this office to help locate and analyze vertebral subluxations.

These X-Rays are not used to investigate for medical pathology. The Doctor at Restore Health 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.

_____ _____

Parent or Authorized Guardian's Signature **Date**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT RESTORE HEALTH.

_____ _____

Parent or Authorized Guardian's Signature **Date**

Medical Information Release Form
(HIPPA Release Form)

Childs' Name: _____ Date of Birth: _____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

The *Release of Information* will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Parent / Guardian's Signature: _____ **Date: _____**