Heartland Family CHIROPRACTIC LLC

Dr. Kami Hansen
Dr. Caroline Ruppert
2850 County Road BB
Cottage Grove, WI 53527
Ph: 608-839-3513 Fax: 608-839-3533

Pediatric Chiropractic Intake Form - Ages 0-5 Years Old

Patient (Child) Information:

Name: _____ Date:_____
Address:_____
Sex: Male Female Date of Birth: _____ Height:_____ Weight: _____
Name(s) of Parents/Guardian:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Email:_____ Would you like our newsletter emailed to you: Y N
How did you hear about our office? _____

Present Complaint: _____
When did this begin?_____ Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N Describe: _____
Current medications: _____

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain: _____
Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section (emergency / planned) Induction Epidural
Complications during delivery? Y N Explain: _____
Genetic disorders or disabilities:_____
How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime:_____
Has your child received vaccinations? Y N If yes, is it the full or graduated schedule?

Feeding History:

☐ Breast Fed; How long: _____
☐ Formula Fed; How long: _____
Introduced to:
Solids at _____ Months
Cows milk at _____ Months
☐ Food Allergies or Intolerances: ☐Y ☐N
List:_____

Childhood Diseases:

☐ Chicken Pox; Age _____
☐ Rubella; Age _____
☐ Mumps; Age _____
☐ Whooping Cough; Age _____
☐ Other: _____ Age _____

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

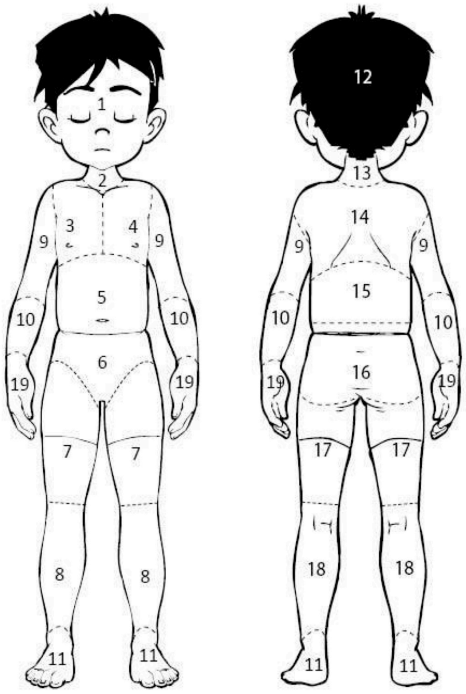
_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Pulls up on Furniture
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N
Explain: _____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N Explain:_____
Other traumas not described above? Y N Explain:_____
Prior surgeries? Y N Explain:_____

DIET: How would you rate your child's diet? ☐Well Balanced ☐Average ☐High sugar/processed foods
SLEEP: Number of hours your child sleeps: _____ hours per night _____hours per day/naps
Sleep Quality: ☐Good ☐Fair ☐Poor



1 – face
2 – neck
3 – left chest
4 – right chest
5 – stomach
6 – abdomen
7 – thighs
8 – legs
9 – upper arms
10 – lower arms
11 – feet
12 – back of head
13 – back of neck
14 – upper back
15 – middle back
16 – lower back
17 – back thighs
18 – back legs
19 – hands

Imagine this picture is your body. Can you color the area that is hurting you right now?

Review of Systems
Please check if your child has had any of the following:

☐ Headaches	☐Ear Infections	☐ADD/ADHD
☐ Postural Imbalances	☐Seizures	☐Frequent Fever
☐ Growing Pains	☐Tonsillitis	☐Colic
☐ Scoliosis	☐Sleep Problems	☐Learning Difficulties
☐ Sensory Processing	☐Constipation	☐Acid Reflux
☐ Asthma	☐Bedwetting	☐Hip Dysplasia
☐ Torticollis	☐Autism	☐Allergies

Informed consent:
The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

****

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/ guardianship of _____, a minor, do hereby authorize Heartland Family Chiropractic and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Any and all x-rays remain property of the clinic as part of patient's permanent record.

ACKNOWLEDGMENT
I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.
COMMUNICATION
May we leave messages on any answering device, i.e. home answering machines or voicemails? □Yes □ N
MISSED APPOINTMENTS
There is a possible $20 fee charged for all appointments that are not cancelled prior to scheduled visit.

Any specific written authorization you provide may be revoked at any time by writing to us at the above address.

Patient: _____ _____ _____
Print Name Signature: Parent/Legal Guardian Date

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #2._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #3._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)

_____
_____
_____
_____
_____
_____
_____