VICTORY CHIROPRACTIC

PEDIATRIC FORM

Name_____ **Date of Birth** ____ /____ /____ **Age**____ **Male/Female**

Address_____ **City**_____ **State**_____ **Zip**_____

Height _____ **Weight**_____ **Grade in School** _____

Guardian(s) Name_____ **Relationship**_____

Phone: Cell (_____)_____ **Home (_____)**_____ **Cellular Provider** _____

List The Health Concerns That Brought You Into This Office

Health Concerns: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had this problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	C I
Second: _____	_____	_____	_____	_____	C I
Third: _____	_____	_____	_____	_____	C I
Fourth: _____	_____	_____	_____	_____	C I

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? □ **YES** □ **NO**

IF YES: □ **CHIROPRACTOR** □ **MEDICAL DOCTOR** □ **OTHER**_____

WHO AND WHEN?_____ **RESULTS?**_____

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE:

__ *Headaches*	__ *Foot Pain*	__ *Loss of Balance*	__ *Diarrhea*	__ *Sleep Problems*
__ *Migraines*	__ *Ear Infections*	__ *Allergies*	__ *Constipation*	__ *Tight/Sore Muscles*
__ *Jaw/TMJ Pain*	__ *Hearing Loss*	__ *Sinus Issues*	__ *Bed Wetting*	__ *Sports Injury*
__ *Neck Pain*	__ *Ringing in the Ears*	__ *Frequent Colds*	__ *Kidney Problems*	__ *Sciatica*
__ *Shoulder Pain*	__ *Dizziness*	__ *Thyroid Issues*	__ *Bladder Problems*	__ *Arthritis/Joint Pain*
__ *Arm Pain*	__ *Loss of Energy*	__ *Asthma*	__ *Fibromyalgia*	__ *GERD/Gastric Reflux*
__ *Upper Back Pain*	__ *Nervousness*	__ *Chest Pain*	__ *Epilepsy/Convulsions*	__ *Tremors*
__ *Mid Back Pain*	__ *Double/Blurry Vision*	__ *Heart Problems*	__ *Numb/Tingling Arms/Hands*	__ *Disc Problems*
__ *Lower Back Pain*	__ *Anxiety*	__ *Nausea*	__ *Numb/Tingling Legs/Feet*	__ *Stomach Problems*
__ *Hip/Leg Pain*	__ *ADD/ADHD*	__ *Ulcers*	__ *Scoliosis*	__ *Difficulty Breathing*
__ *Knee Pain*	__ *Depression*	__ *Digestive Issues*	__ *Poor Posture*	__ *Skin Problems*

Other: _____

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:_____

Past prescription drugs your child has taken_____

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:_____

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.

Headaches Arm Pain

EXAMPLE: **No pain** _____ **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? _____%

Practice Member Name: _____ **Date:** _____

OFFICE ONLY:

Q1____+Q2____+Q4____=____ /3x10=____ (Low Intensity = <50; High Intensity = >50)

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**
Other: _____	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Other: _____	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBERS NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS 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. BRADY WILSON AND ANY AND ALL VICTORY 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 VICTORY CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____

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. If any necessary x-rays are taken, they will remain in our files. At your request, we will provide you with a copy.

THE FEE FOR COPYING YOUR X-RAYS IS $5 PER VIEW. THIS FEE MUST BE PAID IN ADVANCED.

Digital x-rays on cd will be available within 72 hours of prepayment on any regular practice hours day.

PLEASE NOTE: x-rays are utilized in this office to help locate and analyze **vertebral subluxations**. 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 YOUR NAME HERE **DATE**

_____ _____

SIGNATURE **DATE OF BIRTH**