Fitzpatrick Chiropractic

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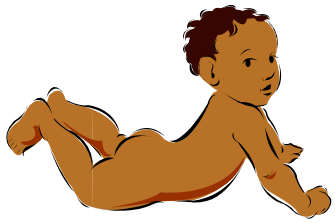
Chiropractic Pediatric Case History Form (Newborn - 18 years of age)

Welcome! I am so honored that you brought your child to see me. I usually receive patents by direct referral, so the likely reason you are here is that someone told you my services were helpful. I respect and appreciate their referral and trust in me. I will do my very best to provide you and your family with the very best chiropractic care possible.

Before we begin, it is important that you understand my approach to chiropractic care and the parameters of my assessment and subsequent diagnosis. **If the following description does not match your expectations, you need to know before we go any further; so please read the following paragraphs carefully before filling out the examination form.** Please sign and provide the date when indicated.

What you can expect this visit: I will assess the health of your child's nervous system, mostly pertaining to the spine. If I believe his or her nervous system, spinal alignment, and health is fine, I will let you know. If I think your child may require the services of other health care professionals, I will refer you to the appropriate resources. If I believe your child is a candidate for chiropractic care, we will develop an appropriate treatment plan for him/her; and, with your agreement, we will proceed accordingly.



What I do: I assess and address subtle functional impairments to the nervous system, primarily by assessing the health of the spine and cranium. The cranium and spinal column (vertebrae, joints, muscles, etc…) house and protect the central and peripheral nervous systems. Chiropractors assess nervous system health and any potential physical, chemical, or emotional interference to that health.

Picture your nervous system as if it were the network of electrical wiring leading to every appliance in your house or auto. If your home's or auto's electrical system experienced shorts, the interference to the electrical system would not allow your appliances or car to function at their full capacity.

In the same way, the nervous system coordinates every function of the body. if you or your child has acquired dysfunctional misalignments or sprains/strains due to injury along the spine or cranium, these injuries could be causing "shorts" in the nervous system. These shorts can cause interference and damage to the nervous system as a whole, and can interfere with the

structure and function of muscles, joints, the body's ability to grow and adapt properly to its environment, and the body's ability to heal quickly and well.

My job as your family's chiropractor is to assess your child's nervous system health, and to check if there are any subtle spinal and cranial misalignments that might be related to any found nervous system interference. After a thorough examination, if I think that your child is a candidate for chiropractic care, I will recommend a course of care that involves the application of gentle, hands-on, corrective adjustments with the intention of helping the body recover nervous system function naturally and to bring ease to the body's various systems.

It is my clinical experience and opinion that an individual's nervous system health is preserved best with regularly scheduled spinal checks, the same way the health of our teeth and gums are best preserved with regularly scheduled dental check-ups. A dentist checks for dental health the way a chiropractor checks for spinal health. Teeth and gums are not considered healthy when they are experiencing decay, even if there is no pain yet. Likewise, a spine is not considered healthy when it has acquired misalignments and injury that could interfere with the nervous system's ability to keep the body healthy… even if there is no pain. The objective of dentistry as well as chiropractic is to maintain the overall health of the body through proper care of the mouth and spine, respectively.

I do not diagnose or cure disease; nor do I directly treat physical symptoms or discomfort. I asses and reduce physical impacts to nervous system in order to help the body correct and heal itself. Then I back off. My job is to help provide a proper physical environment that will allow the body to heal and thrive naturally.

Pain and symptom relief is a probable side effect of chiropractic care, but it is not its goal. There is no way I can honestly guarantee that I can "fix" anything. I will do my best to help your child's body to heal itself, but the healing is up to your child's body.

If I think your child's health concerns require additional and integrative care, I will refer you to appropriate health care practitioners for coordinated, cooperative patient management.

If this statement of purpose is acceptable to you, please sign here and we will get started!

(Signature of parent or guardian) (date

To help me serve you and your child better, please complete the following:

Personal Information

Child's Name:_____

(Legal Last) (Middle Initial) (Legal First)

Gender (circle): M F

Address:_____City/State:_____Zip Code:_____

Age: Years_____ Months_____ Date of Birth: (dd/mm/year) _____

Parent One:_____	Parent Two:_____
Address: _____	Address: _____
Home Phone Number:_____	Home Phone Number:_____
Cell Phone Number:_____	Cell Phone Number:_____
Work Phone Number:_____	Work Phone Number:_____
Email:_____	Email: _____

Legal Guardian/Physical Custodial Parent (if applicable):_____

What is the best way to contact you? _____

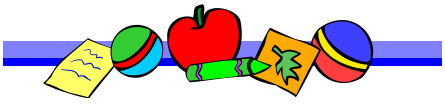
Whom may I thank for referring you to me?_____

Payment Responsibility: Payment is expected at the time of service.

Chiropractic Care: The initial exam (which consists of two visits) for a child up to 18 years of age is €120. Follow up exams/reexaminations are €55. Subsequent chiropractic office visits for children are €55 per visit. There is no VAT for chiropractic care.

Who is responsible for your child's bill? _____

Insurance: Please check with your insurance provider as to whether your policy includes alternative health care coverage for chiropractic care.



Current Health Concerns

Reason why your child is here: (___) Wellness Spinal Check (___) Specific Condition(s) _____

_____

If applicable, is this condition due to an accident or specific event/incident?(___) No (___) Yes

Please explain: _____

Do you feel your child's present diet, environment, and/or physical activity level is related to his/her present health challenge? (___) No (___) Yes, Please explain: _____

Doctor's visit or hospitalization for the current condition?(___) No (___) Yes, please fill out below:

Date:_____Where:_____ Treatment Given:_____

_____

What other treatment options have you attempted to improve the condition? _____

_____

How long has this condition been bothering your child?

(___) 1 week (___) 2-7 weeks (___) 2-4 months (___)greater than 4 months

How often does this condition bother your child?(please check one)

(__)Daily: Hours per Day ____ (__)Weekly: Days per Week ____ (__)Monthly: Number of Months ____

Has your child ever had similar conditions in the past? (___) No (___) Yes, When:_____

This condition is (check one):

(__)Getting worse (__)Staying the same (__)Slowly improving (__)Rapidly improving

Do any particular activities or movements (standing, sitting, lying down, bending, twisting, lifting, walking, etc.) aggravate the condition?_____

Is this condition interfering with: School (___) Sleep (___) Concentration (___) Daily Routine (___)

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health: _____

Birth History

Obstetrician/Midwife Name:_____Contact Info:_____

Delivery Method (please check all that apply): (__) Vaginal (__) Forceps (__) Vacuum Extraction (__)

Caesarean Section (__) Medication during pregnancy or delivery

What position was the child in during delivery?_____

Was the mother under chiropractic care during the pregnancy? (__) No (__) Yes

Any complications during the pregnancy or with the delivery?(__) No (__) Yes, explain: _____

_____

Any known congenital anomalies / defects?(__) No (__) Yes, please explain:_____

Past Health Information

Family Doctor Name/ Pediatrician Dr.'s Name_____

Clinic Name/Location_____Contact Info:_____

Date of Last Visit _____ Has your child had previous chiropractic care?(__) No (__) Yes

If Yes, Dr.'s Name_____

Clinic Name/Location_____Contact Info:_____

Date of Last Visit _____Please describe the reason for previous care:_____

Has your child ever been in an auto accident?(__) No (__) Yes (please provide info below)

Approximate Date:_____Describe Incident_____

Has your child had courses of vaccinations?(__) No (__) Yes (please list. Use the back if necessary)

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Approximate Date:_____Describe:_____

Has your child had any other major injuries, falls, head injuries, or accidents?(__) No (__) Yes (please explain)

Approximate Date:_____Describe Incident:_____

Approximate Date:_____Describe Incident:_____

Approximate Date:_____Describe Incident:_____

Has your child had any broken bones or dislocations?(__) No (__) Yes, which?:_____

Is your child involved or ever been involved in any high impact or contact sports (wrestling, football, soccer, gymnastics, baseball, martial arts, etc.)?(___) No (___) Yes, please list:_____

Has your child had any surgical operations or been hospitalized?(__) No (__) Yes (please provide info below)

Approximate Date:_____Describe:_____

Family Health History

Please indicate if any of the following conditions are known in your family:

(_) Cancer (Relationship to child:_____) (_) Diabetes Type ____ (Relationship to child_____)

(_) Heart Disease (Relationship to child:_____) (_) Headaches(Relationship to child:_____)

(_) Other:_____(Relationship to child:_____)

Vital Health Information

Current Weight:_____Current Height or Length:_____ Do you notice any developmental delays with your child? (___) No (___) Yes, explain:_____

Current Habits

Please check any of the below habits that your child has:

(__) Junk Food (__) Healthy Foods (__) Soda/High Sugar Fruit Drink Intake (__) High Level of Activity/Exercise (__) Low Level of Activity/Exercise (__) Stress (__) Lack of Focus (__) Difficulty in School(__) Smoking (__) Drinking Alcohol (__) Excessive Television/Computer/Video Game use

Medication/ Supplementation

Please provide any nutritional supplement, over-the-counter medication, or prescription medication taken by the child in the last year. Please include vaccinations and antibiotics, and use the back of the form as needed.

Supplement/Medication Name _____ Supplement/Medication Name _____

Amount Taken (mg) _____ Amount Taken (mg)_____

Frequency of Administration (_____ x per_____) Frequency of Administration (_____ x per_____)

How long (s)he has been taking it _____ How long (s)he has been taking it _____

Reason for Supplement/Medication _____ Reason for Supplement/Medication_____

Review of Health Systems

Has your child ever suffered from: (Check all that apply)

General

__Headaches/Migraines
__Convulsions/Epilepsy
__Tremors
__Loss of Balance
__Dizziness/Vertigo
__Fainting
__Sleeping Problems
__Colic
__Cold Sweats
__Weight Problems
__Loss or gain of a significant amount weight within 6 months
__Jaw/TMJ Problems
__Ruptures/hernias

Serious Illnesses/Diseases

__Chicken Pox (Age:___)
__Measles (Age:___)
__Mumps (Age:___)
__Rubella (Age:___)
__Whooping Cough (Age:___)
__Rubeola (Age:___)
__HIV/AIDS (Age:___)
__Cancer (Age:___, Type:_____)
__Thyroid Problems
__Liver Trouble/Hepatitis
__Kidney Problems
__Diabetes Type I or II
__Other:_____ (Age:___)

Emotional/ Mental

__Nervousness/Anxiety
__Unexplained Fatigue
__Depression
__Irritability/Mood Swings
__Tension/Stress
__Behavioral Issues
__Hyperactivity

Integumentary System

__Skin Problems
__Rashes
__Hives
__Skin Sensitivity
__Easy Bruising

Ears, Eyes, Nose, Throat

__Frequent Colds/Flu
__Blurred Vision R/L
__Double Vision R/L
__Ear Infection
__Loss of Smell
__Buzzing/Ringing in ears
__Sinus Problems
__Allergies
__Recurrent Ear Infections
__Tooth Abscess
__Difficulty Hearing

Musculoskeletal System

__"Growing" Pains
__Neck Stiffness/Pain
__Mid-Back/Rib Stiffness/Pain
__Low Back Stiffness/Pain
__Hip Pain R/L
__Fractured Bones
__Swollen Painful Joints
__Muscle Problems
__Difficulty Walking
__Scoliosis
__Shoulder/Elbow Problems
__Wrist/Hand Problems
__Knee/Ankle/Foot Problems

Gastro-Intestinal System

__Gall Bladder Problems
__Digestive Problems
__Stomach Upset
__Heartburn/Reflux
__Diarrhea/Constipation/Gas
__Poor appetite
__Food allergies or intolerances

Genito-Urinary System

__Recurring Infections
__Difficulty Urinating
__Bed Wetting

Cardiovascular System

__Diabetes Type I or II
__High Blood Pressure
__Chest Pain
__Heart Problems
__ Anemia

Respiratory System

__Asthma
__Chronic Cough/Cold
__Difficulty Breathing
__Pain w/Cough / Sneeze
__Shortness of Breath
__Lung Problems
__Recurring Infections
__Sinus Problems

Nervous System

__Numbness/Tingling/Pain in (Arm/Hands/Fingers)
__Numbness/Tingling/Pain in (Buttocks/Thighs/Legs/Feet/Toes)
__Cold Hands

Reproductive System

__Urinary Tract Infections
__Pelvic Pain
Males Only:
__Prostate/Sexual Dysfunction
Females Only:
__Menstrual Cramping
__Menstrual Irregularity
__Vaginal Pain/Infection
__Breast Pain/Lumps

Age of first menstrual period: _____Date of last menstrual period: _____
Is there any chance the patient might be pregnant?***** ____Yes ____No ____ Not sure
*****A referral for X-rays may be advised during the exam and x-rays can damage fetal development.

Signature of guardian verifying patient is NOT pregnant: _____

Is there any further information you would like to share that this form did not cover? Please write below.

Patient Informed Consent and Authorization for Care of Minor:

You are the decision maker for your child's health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your child's condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your child's circumstances and health care as you see fit.

I have read, or have had read to me, the above Consent to Care. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation for my child to receive chiropractic care as is deemed appropriate for his/her circumstance. I intend this consent to cover the entire course of care from all providers in this office for my child's present condition and for any future condition(s) for which I seek my child's chiropractic care from this office.

Signature of Parent or Legal Guardian Date

Patient Consent for Use and Disclosure of Protected Health Information:

With my consent Fitzpatrick Chiropractic may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer Fitzpatrick Chiropractic Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing the consent. Fitzpatrick Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to Fitzpatrick Chiropractic, Attn: Privacy Officer Weesperstraat 61 1018 VN. With my consent, Fitzpatrick Chiropractic may call my home, or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and calls pertaining to my clinical care. Also, with my consent, Fitzpatrick Chiropractic may send mail to my home involving the above items named in this paragraph pursuant to my clinical care as long as they are marked personal and confidential. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by its agreement. By signing this form, I am consenting to the use by Fitzpatrick Chiropractic of my protected health information to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, the doctors at Fitzpatrick Chiropractic may decline to provide treatment to me.

Do you have any questions regarding the above authorization statement?

(__) No (__) Yes, Please explain: _____

Parent/Guardian Name: (Please PRINT) _____

Parent/Guardian Signature: _____ Date: _____

Doctors Initials _____