FLOWER OF LIFE
CHIROPRACTIC

PED NEW MEMBER HEALTH SURVEY

Child's Name_____ Sex: ❑ M ❑ F DOB___/____/___ Age____

Parent's Name _____

Address_____ City_____ State_____ zip _____

E-mail_____@_____.com Phone_____

Sibling's Name & Age(s)_____

How did you find our office? _____

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

We are going to ask you a variety of questions that give us more information about your child's past and present experiences. These experiences affect your child's physiology and directly affect their physical, mental, emotional and spiritual wellbeing. These experiences fall into three categories; physical (trauma), mental/emotional/spiritual (thoughts) and chemical (toxins). If this experience was too much for your system to handle it locks down as a tonal shift (tension) which can lead to a variety of symptoms. Please fill the form out to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.

CHILDS HISTORY - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on mom but also on baby.*

Was this birth planned? ❑ Y ❑ N Were fertility measures taken? _____

Did mom use any of the following during pregnancy: ❑ Tobacco ❑ Alcohol ❑ Medications _____ ❑ Drugs

Did any occur during pregnancy: ❑ Falls or Injuries ❑ Abuse (physical, sexual, emotional) ❑ Complications

Please describe your stress level during this pregnancy _____

CHILD'S BIRTH HISTORY

Where did you give birth: _____ Provider: _____

At What Week of Pregnancy Was Your Baby Born?_____ Doula? _____

Were you happy with your birth providers? ❑ Y ❑ N _____

Baby's Position at time of Delivery: ❑ Head Down ❑ Posterior ❑ Facial ❑ Brow ❑ Breech

Birthing Position: ❑ On Back with Feet up ❑ On Side ❑ Squatting ❑ Kneeling ❑ Other: _____

Was baby's birth: ❑ Vaginal without assistance ❑ Vaginal with Assistance (❑ Forceps ❑ Vacuum Extraction)

❑ C- Section ❑ Induced labor prior to natural contractions ❑ Acupuncture Induced ❑ Cytotec ❑ Epidural

❑ Ruptured Membranes ❑ Pain Medications or Anesthesia ❑ Antibiotics ❑ Episiotomy/tear ❑ Ptocin

How Long was Labor? _____ How long was delivery (pushing)? _____

Baby's APGAR Scores: _____ Any Visible Injury to Baby? ❑ Y ❑ N _____

Did you: Do Skin to Skin ❑ Y ❑ N (how soon after) _____ Vaginal Swab ❑ Y ❑ N

Delay Cord Clamping ❑ Y ❑ N (how long) _____ Uninterrupted family time ❑ Y ❑ N (how long)_____

Was baby separated ❑ Y ❑ N (how long) _____ Did baby latch right away? ❑ Y ❑ N (how long) _____

Was baby circumcised? ❑ Y ❑ N when? _____ Bathed ❑ Y ❑ N (when) _____

Any evidence of trauma during birth: ❑ Bruises ❑ Odd shaped head ❑stuck in birth canal ❑ fast and/or Excessively long birth ❑ Respiratory Depression ❑ Cord around neck ❑ other _____

Complications during birth _____

APGAR at Birth_____ APGAR after 5 min _____ Birth Weight _____ Birth Length _____

The birth was…_____

PHYSICAL STRESSORS (other)

Any Lip or Tongue Tie: ❑ Y ❑ N Who did revision & When? _____

Surgery (& year performed) : _____

Accidents: _____

Falls: _____

Sports (past & present): _____

PSYCHOLOGICAL STRESSORS

Any difficulties with nursing? ❑ Y ❑ N Any problems bonding? ❑ Y ❑ N

Does your child seem normal to you? ❑ Y ❑ N _____

Does your child have any behavioral problems? ❑ Y ❑ N _____

Does your child have difficulty sleeping/ night terrors/ bed wetting? ❑ Y ❑ N _____

How has/was Mom's healing postpartum? _____

How long is/was Maternity Leave? _____ Do/Did you have assistance with baby? ❑ Y ❑ N

CHEMICAL STRESSORS- *Anything inhaled, ingested or absorbed*

Was your child breast fed? ❑ Y ❑ N How Long? _____ Pain / Clicking / Breast refusal ?

Does your child feed: ❑ On both sides equally ❑ On Schedule ❑ On Demand Fed Formula: ❑ Y ❑ N

When was the introduction of food? _____ What were first foods? _____

Medications (type & reason): _____

Allergies? ❑Y ❑ N Please list with reaction _____

Vaccine History: ❑ Full CDC ❑ Selective schedule ❑ Delayed schedule ❑ None

Reaction to Vaccine ❑ Y ❑ N (please explain)_____

CURRENT HEALTH CONCERNS

What is the reason for this reservation?_____

When did this begin?_____ Have they had this before? _____

Why do you think this is occurring?_____

Is there any other issue/secondary condition that you believe is related to this?_____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

_____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? ❑ Y ❑ N If yes, when? _____

Does it affect: ❑ Mood, patience, attitude ❑ Sleep ❑ exercise or play ❑ day-to-day activities ❑ Ability to work ❑ decision making ❑ relationship or intimacy

Have you been to a chiropractor? ❑ Y ❑ N Has your child been to a chiropractor before? ❑ Y ❑ N

What are your healthcare goals? _____

DEVELOPMENTAL MILESTONES-

Age	Milestone	Not Met	Met	Delayed by	Age	Milestone	Not Met	Met	Delayed by
1 Month	Fist Clench				8 Months	Sits Unaided			
2 Months	Smiles					Plays with Hands			
	Hands Open					2 Syllable word "dada"			
	Cooing				9 Months	Pulls to Stand			
3 Months	Head Control					Shows Joy/ Displeasure			
	Opens Mouth				12 Months	Crawling			
4 Months	Laughs					Pull to stand			
	Looks at object in hand					Walk with support			
5 Months	Back to Stomach					Finger Feeds			
6 Months	Sits Alone				15 Months	Walks Alone			
	1 Syllable word "da"					Says 4-5 Words			
	Reaches					Indicates Wants			
	Roll Over					Names objects			

SECONDARY CONDITIONS- *Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.*

Past	Now		Past	Now	
☐	☐	ADD / ADHD	☐	☐	Ear Infections
☐	☐	Anxiety / Depression	☐	☐	Early Intervention
☐	☐	Asthma / Respiratory Issues	☐	☐	Frequent Cold / Flu
☐	☐	Athletic Injuries	☐	☐	Headaches
☐	☐	Autism Spectrum	☐	☐	Growing Pains
☐	☐	Bed Wetting	☐	☐	Learning Difficulties
☐	☐	Behavior Issues	☐	☐	Plagiocephaly / Flat Head
☐	☐	Bowel / Bladder Changes	☐	☐	Neck Pain
☐	☐	Breastfeeding Issues	☐	☐	Reflux
☐	☐	Broken Bone	☐	☐	Scoliosis
☐	☐	Cancer	☐	☐	Seizures
☐	☐	Colic	☐	☐	Sensory Integration Issues
☐	☐	Concussion / Head Injury	☐	☐	Skin Condition
☐	☐	Constipation	☐	☐	Sleeping Issues
☐	☐	Dental / Jaw Issues / Braces	☐	☐	Sinus Problem / Allergies
☐	☐	Developmental Delays	☐	☐	Surgery
☐	☐	Digestive Issues	☐	☐	Tongue Tie / Lip Tie / Cheek Tie
☐	☐	Dizziness / Vertigo	☐	☐	Thyroid Disorder
☐	☐	Eye / Vision Issues	☐	☐	Weight Changes
			☐	☐	Other _____

YOUR CHILD'S HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS ECT)

Provider Name	Provider Type	Last Visit	Reason	Result

Patient Signature _____ Date _____

Entered into Computer _____ initial _____

Informed Consent

We encourage and support a shared decision making process between us regarding your health needs. As part of that process, you have a right to be informed about the condition of your health, recommended care, and treatment. By providing with this information, you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science that concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and / or does not move properly. This subluxation causes interference or irritation to the nervous system. The primary goal in chiropractic care is the removal and / or reduction of nerve interference caused by vertebral subluxations.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpitation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce more correct vertebral subluxation(s). There are a number of different methods or techniques by which chiropractic adjustment is delivered, but are typically delivered by hand. Some clients may require the use of an instrument or other specialized equipment . In addition, physiotherapy or rehabilitative procedures may be included in the wellness management protocol. Among other things, chiropractic care may reduce pain, increased mobility, and improved quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care period the risks are seldom high enough to contraindicate care in all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care. This includes the risk that care received may not accomplish the desired objective. Reasonable alternative treatments have been explained including the risks, consequences , and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraph. I understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Flower of Life Chiropractic to proceed with chiropractic care and treatment. Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature Doctor’s signature

Notice of Privacy Practices for Protected Health Information

This Notice of Privacy Practices for Protected Health Information (PHI) describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Flower of Life Chiropractic to use and/or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATION (Please Read & Initial):

_____ I give permission to Flower of Life Chiropractic to use my address, phone number, and e-mail to contact me with appointment reminders, missed appointments, birthday cards, and newsletters.
_____ I would NOT like to receive Text Appointment Confirmations / Reminders
_____ I would NOT like to receive E-mail Reminders Confirmations / Reminders

_____ If Flower of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

_____ I give Flower of Life Chiropractic permission to adjust me in the adjustment suite which is a room where 1-3 other clients may also be getting adjusted. I am aware that other persons may overhear some of my protected health information during the course of care if I share that information in the open suite. I am aware that Flower of Life chiropractic can provide private space for any conversation about private health information if desired.

_____ I give Flower of Life Chiropractic permission to be in contact and Co-Manage my care with another member of my Health Care Team.

_____ I would like to request itemized statements for insurance reimbursement purposes.

The use of this format is intended to make your experience more efficient and productive as well as to enhance your access to quality health care in health information. This authorization will remain in effect for the duration of my care at Flower of Life Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this authorization, in writing, at anytime. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the privacy official of flower of life chiropractic. The written notice must contain all of the following information:
Your name, Social Security number, and date of birth
A clear statement of your intent to revoke this authorization
The date of your request
Your signature

The revocation is not effective until it is received by the privacy official this authorization is requested by Flower of Life Chiropractic for its own use slash disclosure of PHI. (*minimum necessary standards apply)*

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, Flower of Life Chiropractic will not refuse to provide treatment. I will be personally responsible for:
1) Payment in full at the time of services that are provided to me
2) Scheduling my own appointments since Flower of Life Chiropractic will be unable to contact me
3) All contact with Flower of Life Chiropractic regarding my care.

I have read and understand this Health Care Authorization form and acknowledge the receipt of the Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's Name (please print): _____

Patient or Guardian's Signature: _____ Date: _____

PEDIATRIC ASSESSMENT

Name_____ Asmt #_____ Date___/____/___ Age ____Cat_____ Score_____%

Posture: ____

L R _____Head tilt
L R _____Head & Neck extension/flexion
L R _____Head shape
L R _____Rigid legs in extension
L R _____Rotation
L R _____Foot flare in/out
L R _____Gluteal Fold

Category: 1 (-2) **2** (-7) **3** (-10)

Atlas- head rotate away from side of lateral atlas.

(hip joint bogginess on same side of lesion→ occiput on the look away side)

Cervical ROM _____ ____

Pediatric Tests: **Expected Integration** ____

Acoustic blink	+ -	
Ortolani's Reduction	+ -	
Moro	+ -	2-4 Mo (flex & extension of limbs)
Placing(0-6w)	+ -	Before Walking
Sucking(0-4m)	+ -	0-4 moths
Parachute (6m-1yr)	+ -	Absent until 6-10 mo
Neck righting	+ -	0-4 M
ATNR	+ -	2 w - 4 m (turn head L & R—> arm ex on face side)
Light response	+ -	
STNR	+ -	**5-6 m** Prone= Limb flexion, supine= limb extension

Primitive Reflexes:	**L**	**R**	**Expected Integration**
Rooting	+ -	+ -	**3-4 M**
Palmar	+ -	+ -	**3 M**
Plantar	+ -	+ -	**8 M**
Galant	+ -	+ -	**3-9 M**
Babinski	+ -	+ -	**12 M**

Leg Length: L R 0 ⅛ ¼ ½ ¾ ____

Heel tension: L: N D I R: N D I ____

Sacrum: L R Mild Moderate

Sacral Dural Pump: O: P L A S: P L A (0,5,7,10) ____

Disconnections: _____ (-1 per) ____

Muscular/Ligamentous Patterns: 1 2 3 4 5 6 (3,7,10) ____

Osseous Subluxations_____(-2 for each) ____

Cranium: Occiput: L R Frontal: L R Parietal: L R Temporal: L R Sphenoid: L R ____

Sutures: Sagittal Coronal Occipital Parietal Lambdoidal ____

Notes:

_____
_____
_____
_____
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_____
_____
_____

- FOR OFFICE USE ONLY -