INNATE CHIROPRACTIC & WELLNESS

INFANT/CHILD HEALTH HISTORY

Today's Date_____

ABOUT THE INFANT/CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Cell phone (_____) _____	Cell phone (_____) _____
Occupation _____	Occupation _____
E-mail _____	E-mail _____

Whom may we thank for referring you to our office? _____

REASONS FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel we can address for your child? _____

_____

Related to: ❑ Sports ❑ Wellness ❑ Injury ❑ Chronic ❑ Auto ❑ Other _____

Are your child's symptoms affecting their quality of life? ❑ Yes ❑ No

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

Please describe how these concerns affect your child. _____

_____

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

INFANT/CHILD HEALTH HISTORY

The primary system in the body, which coordinates health, is the NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. A MISALIGNMENT in the SPINE and NERVOUS SYSTEM is a condition called a VERTEBRAL SUBLUXATION. A VERTEBRAL SUBLUXATION results in nerve malfunction, which results in less communication between the affected NERVES and the function of the BODY.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol? _____
❑ Receive Ultra-Sounds: ❑ Yes ❑ No How many? _____ Type of Ultra-Sounds? ❑ 3D ❑ 4D

Type of Birth:
❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score at Birth _____ APGAR Score at 5 minutes _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

Please check all that apply to the baby's current status (Ages 0-18 months ONLY):

❑ Collic/Constant Cry ❑ Latch Issues ❑ Digestion ❑ Not Crawling/Scooting
❑ Feeding to one side ❑ Arching of back ❑ Constipation ❑ Other Conditions _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ MMR _____ ❑ Other _____
❑ Polio _____ ❑ Chicken Pox _____
❑ Hepatitis _____ ❑ Flu _____

Please describe any and all reactions to vaccine(s)_____

Is/Has your child:
❑ Been exposed to second hand smoke?
❑ Taken antibiotics? Explain _____
❑ Currently taking medication? Explain _____
❑ Currently taking any supplements (Vitamins/Probiotics)? Explain _____
❑ Had allergies (seasonal, food, etc)? Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Onset of symptoms was: ❑ Sudden ❑ Gradual ❑ Injury ❑ Chronic ❑ Auto

Is/Has your child:

❑ Uncoordinated/Accident prone? Explain: _____
❑ Been hospitalized? Explain: _____
❑ Had a severe trauma? Explain: _____
❑ Been in an automobile accident? Explain: _____
❑ Has fractured a bone or dislocated a joint? Explain: _____
❑ Had a chronic illness? Explain: _____
❑ Had surgery? Explain: _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling
❑ Other: _____

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No
If yes, please explain: _____

HEALTH CARE PRACTICIONER HISTORY

Has your child ever received chiropractic care? ❑ Yes ❑ No Name of D.C. _____

FINANCES

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

*Accounts will be auto-debited each month on the date of sign-up.

**Insurance coverage isn't necessary in our office. Our fees are constructed to give you the care you need.

We are much more concerned about you than we are about your coverage.

PLEASE READ AND SIGN

1. I acknowledge Innate Chiropractic & Wellness has informed me they are not accepting insurance assignment. Therefore, they cannot guarantee claims for any services rendered to me by Dr. Rachel Settles. I clearly understand and agree all services rendered are charged directly to me and I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. All services rendered will be paid in full each visit, or via monthly auto draft.
2. I have been informed that a copy of Innate Chiropractic & Wellness *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both at the office
3. I consent to receive communication from Innate Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No
   If I should withdraw my consent, I will notify the office in writing.
4. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Rachel Settles, of Innate Chiropractic & Wellness, permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____

Signature _____ Date: _____

Dr. Signature _____ Date: _____

Thank you for choosing Innate Chiropractic & Wellness.
We look forward to helping you.