

**Upper Cervical Health Centers**  
Pediatric Health History Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone :( H) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

**Circle all that Apply**

**1. Was child's birth traumatic?**

|                                     |     |       |
|-------------------------------------|-----|-------|
| Long Delivery?                      | Y N | _____ |
| Difficult Delivery?                 | Y N | _____ |
| Forceps?                            | Y N | _____ |
| Caesarean?                          | Y N | _____ |
| Breach/cephalic                     | Y N | _____ |
| Home birth?                         | Y N | _____ |
| Mother given drugs during delivery? | Y N | _____ |

**2. Growth and Development**

Did child ever once....

|                                  |     |       |
|----------------------------------|-----|-------|
| Fall out of bed?                 | Y N | _____ |
| Bang their head?                 | Y N | _____ |
| Breastfeed?                      | Y N | _____ |
| Have childhood sickness?         | Y N | _____ |
| Have any accidents?              | Y N | _____ |
| Have surgery?                    | Y N | _____ |
| Take drugs?                      | Y N | _____ |
| Fall while learning how to walk? | Y N | _____ |
| Bullied by siblings?             | Y N | _____ |
| Chair pulled out when sitting?   | Y N | _____ |
| Fall down the stairs?            | Y N | _____ |
| Pulled by their arm?             | Y N | _____ |
| Experience other traumas?        | Y N | _____ |

**3. Current Health Habits**

Does child

|                                       |     |       |
|---------------------------------------|-----|-------|
| Smoke?                                | Y N | _____ |
| Drink alcohol?                        | Y N | _____ |
| Consume healthy foods?                | Y N | _____ |
| Take any drugs? (Prescriptive         | Y N | _____ |
| Or non-prescriptive)?                 | Y N | _____ |
| Have teeth problems?                  | Y N | _____ |
| Have hearing problems?                | Y N | _____ |
| Exercise regularity?                  | Y N | _____ |
| Have sleeping problems? (nightmares)? | Y N | _____ |
| Have physical stress?                 | Y N | _____ |
| Have mental stress?                   | Y N | _____ |

Have hobbies/sports injuries? Y N \_\_\_\_\_

Childs normal sleeping posture (CIRCLE) on side on stomach on back

**Current Health Condition**

Major complaint/reason for visit today \_\_\_\_\_

Pain or problem started on \_\_\_\_\_

Pains are:(Circle one) Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with sleep? \_\_\_\_\_ Daily activities? \_\_\_\_\_ School? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

**Other symptoms:**

- Headaches
- Neck pain
- Sleeping problems
- Back pain
- Nervousness
- Tension
- Irritability
- Chest pains
- Face flushed
- Neck stiff
- Pins & needles in legs
- Pins & needles in arms
- Numbness in fingers
- Numbness in toes
- Shortness of breath
- Fatigue
- Light sensitive eyes
- Loss of memory
- Ears ring
- Fever
- Fainting
- Cold sweats
- Loss of taste
- Dizziness
- Feet cold
- Hands cold
- Stomach upset
- Constipation
- Loss of balance
- Buzzing in ear
- Diarrhea
- Depression

What medications are currently being taken? (Include vitamins, supplements and over the counter drugs)

Has the child had surgery or any medical procedure? If "yes" describe procedure(s) \_\_\_\_\_

What side effects, if any, has the child experienced from medications or surgery? \_\_\_\_\_

Is there a family history of: (check all that apply)

|               |                          |                          |                          |                          |                          |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|               | Heart Disease            | Arthritis                | Cancer                   | Diabetes                 | Other _____              |
| Father's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (i.e. cold laser or low level laser therapy) (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient (Or Guardian): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Doctor of Chiropractic: \_\_\_\_\_

Date: \_\_\_\_\_

## UPPER CERVICAL HEALTH CENTERS

With my consent, Upper Cervical Health Centers Of America may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Health Centers of America Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCHCA reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UCHCA.

With my consent, UCHCA may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care. With my consent, UCHCA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Upper Cervical Health Centers of America's use and disclosure of my PHI to carryout TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance up on my prior consent. If I do not sign this consent, Upper Cervical Health Centers Of America may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

### Consent for shared Information with Family and Friends (please check box)

\_\_Yes      \_\_No

I wish family members and friends to have access to my health care information. The name(s) listed below are family members or friends to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

| NAME     | RELATIONSHIP |
|----------|--------------|
| 1. _____ | _____        |
| 2. _____ | _____        |

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.