KEYSTONE CHIROPRACTIC

Pediatric Practice Member

Name: _____ Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Child's Social Security #: _____

Guardian(s) Name: _____ Relationship: _____

Guardian's Email Address: _____ Phone Number: _____

Who may we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW

Health Concern: (List according to severity)	**Rate of severity** 0 = no pain 10 = unbearable	**When did this problem start?**	**Have you had the problem before? If so, when?**	**Did the problem begin with an injury?**	**Are symptoms Constant (C) Intermittent (I)?**
First:					
Second:					
Third:					

Have you seen other doctors for these conditions? ☐ Yes ☐ No

If Yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other: _____

Who? _____ When? _____ Results? _____

Has your child experienced any bowel or bladder problems since this problem began? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever experienced this problem before? ☐ Yes ☐ No If yes, when? _____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

____Headaches	____Ear Infections	____Sinus Issues	____Kidney Problems	____Sexual Dysfunction
____Migraines	____Hearing Loss	____Frequent Colds	____Bladder Problems	____Sleep Problems
____Jaw/TMJ Pain	____Ringing in the Ears	____Thyroid Issues	____Menstrual Problems	____Tight/Sore Muscles
____Neck Pain	____Dizziness	____Asthma	____Prostate Problems	____Sports Injury
____Shoulder Pain	____Loss of Energy	____Chest Pain	____Infertility	____Sciatica
____Arm Pain	____Nervousness	____Heart Problems	____Fibromyalgia	____Arthritis/Joint Pain
____Upper Back Pain	____Double/Blurry Vision	____Nausea	____Epilepsy/Convulsions	____GERD/Gastric Reflux
____Mid Back Pain	____Anxiety	____Ulcers	____Tremors	____Numb/Tingling in Arms/Hands
____Lower Back Pain	____ADD/ADHD	____Digestive Issues	____Disc Problems	____Numb/Tingling in Legs/Feet
____Hip/Leg Pain	____Loss of Balance	____Diarrhea	____Scoliosis	____Stomach Problems
____Knee Pain	____Depression	____Constipation	____Poor Posture	____High/Low Blood Pressure
____Foot Pain	____Allergies	____Bed Wetting	____Skin Problems	____Difficulty Breathing

Other(s): _____ _____ _____

____Scoliosis ____Cancer ____Spina Bifida ____Spinal Surgery ____Diabetes

____Spinal Bone Fracture ____Arthritis ____Seizures Other: _____

Pregnancy Information

Overall, how was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy? _____

Other pertinent information: _____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Cesarean Section

Induced? ☐ Yes ☐ No If yes, please explain: _____

Medications during delivery? _____

Other information: _____

Post Birth Information

Birth Weight: _____ Birth Length: _____

Breast Fed? ☐ Yes ☐ No If yes, how long? _____ Formula Fed? ☐ Yes ☐ No If yes, how long? _____

Solid foods introduced at _____months Food allergies or intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months: _____ Total Lifetime: _____

Please list any medication your child currently taking, its dosage, and purpose: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

List all surgical operations and years: _____

Has your child ever been knocked unconscious? ☐ Yes ☐ No Has your child ever fractured a bone? ☐ Yes ☐ No

If yes to either of the above, please describe: _____

Has your child ever been in a car accident? ☐ Yes ☐ No If yes, did they sustain an injury? ☐ Yes ☐ No

Please explain: _____

Does your child participate in organized sports? ☐ Yes ☐ No If yes, have they ever sustained an injury? ☐ Yes ☐ No

Please explain: _____

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 complaint.

EXAMPLE: No Pain Back pain Headaches 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? _____%

PLEASE PRINT NAME HERE **DATE**

ACTIVITIES OF LIFE

Please identify how your child's current condition is affecting their ability to carry out activities that are routinely part of their 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
Playing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration at School	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

PLEASE PRINT NAME HERE **DATE**

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 chiropractic 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 findings 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.
- I authorize and request payment of insurance benefits directly to Jared Byington, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____

PRINT NAME OF GUARDIAN

_____ _____

GUARDIAN SIGNATURE **DATE**

WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: _____

I authorize Dr. Jared Byington and any and all Keystone 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 Keystone Chiropractic.

_____ _____

GUARDIAN SIGNATURE **DATE**

_____

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 physician's 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.

GUARDIAN SIGNATURE **DATE**

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. There is no fee for a requested copy of x-rays. However, advanced notice is appreciated. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Keystone 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 NAME OF GUARDIAN **CHILD'S DATE OF BIRTH**

GUARDIAN SIGNATURE **DATE**