



Mahalko Family Chiropractic
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Pediatric Information Form for ages 5 Years and Younger

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Full Name _____

Parent(s) Name _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Date of Birth _____ Age _____ Social Security Number _____

Parent's Employer _____ Address _____

Whom may we thank for referring you? _____

Chiropractors child has seen before:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List medical doctors seen within the past year:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? _____

Type _____ When _____ Hospitalized? _____

List all surgeries:

Type _____ When _____

Type _____ When _____

List medications and/or vitamins and supplements child is taking:

Type _____ For _____ How long _____

Type _____ For _____ How long _____

Use back of sheet for any additional space needed.

PEDIATRIC PATIENT INFO AND CARE HISTORY

Name: _____ Date: _____

Birthdate: ___/___/___ Age: _____ Sex: _____ Number of Siblings: _____

Chief Complaint: _____

Explanation of Incident or Condition: _____

Date of Onset: _____ Did symptoms appear gradually or suddenly?: _____

Birth and Care History:

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length/Height: _____

Third Trimester Presentation: Vertex _____ Breech _____ Transverse _____ Face/Brow _____

Type of Birth: Normal Vaginal _____ Forceps _____ Caesarean _____ Suction Cap or Vacuum _____

Location: Home _____ Birthing Center _____ Hospital _____

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: _____ Was There Presence At Birth Of:

Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects? _____ If yes, please explain? _____

Infant Feeding: Breast _____ Bottle _____ If Bottle, Which Formula? _____

Number of Hours Sleeping Per Night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____

Immunization History: _____

Number of Doses of Antibiotics Your Child Has Taken:

During the Past 6 Months _____ During His/Her Lifetime _____

Has Your Child Ever Been Treated On An Emergency Basis? _____ If yes, please explain.

PEDIATRIC DIET AND CONDITIONS HISTORY

Name: _____ Date: _____

At what age were solids introduced _____ which food(s) were given first _____

Does your child consume milk? _____ if yes, how many glasses a day? _____

Dairy (cheese, yogurt, etc) _____ if yes, how much in a day? _____

Does your child have any food allergies? If so, to what? _____

Does your child drink water throughout the day? _____ if yes, how many glasses? _____

Juice _____ Soda _____

Has the child ever suffered from? (Check all that apply.)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Other _____ |

Has the child ever suffered the following spinal traumas? (Check all that apply.)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard | <input type="checkbox"/> Fall off skates |
| <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall from highchair | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall down stairs | <input type="checkbox"/> Fall from counter | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off slide |
| Other : | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____

Rubeola _____ Whooping Cough _____ Other _____ Other _____

OFFICE PROCEDURES AGREEMENT

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME APPOINTMENT REMINDERS AND/OR MISSED APPOINTMENT CORRESPONDENCE BY PHONE OR VIA US MAIL OR OTHER SIMILAR METHODS.

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE PHONE MESSAGES OR VERBAL MESSAGES WITH WHOEVER ANSWERS THE PROVIDED PHONE NUMBERS REGARDING APPOINTMENT INFORMATION.

I UNDERSTAND THAT PERSONAL HEALTH INFORMATION WILL ONLY BE SHARED BY PHONE WITH ME AS THE PATIENT OR TO LEGAL GAURDIANS IF THE PATIENT IS A MINOR.

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND NEWSLETTERS OR OTHER PRINTED MATERIAL TO ME VIA US MAIL OR OTHER SIMILAR METHODS. TO BE REMOVED FROM THIS LIST, I MAY REQUEST TO BE RELEASED AS AN ACTIVE PATIENT.

MAHALKO FAMILY CHIROPRACTIC WILL PREPARE AND FILE INSURANCE FORMS AND REPORTS IF I WISH TO FILE WITH INSURANCE. CASH PAYMENTS AND INSURANCE COPAYS AND ESTIMATED INSURANCE COPAYMENTS ARE DUE AT THE TIME SERVICE IS PROVIDED.

BY SIGNING BELOW, I AGREE TO THE INFORMATION ABOVE, SERVICES TO BE RENDERED, AND RESPONSIBILITY OF CHARGES INCURRED AT THIS OFFICE. IF INSURANCE DOES NOT COVER FILED CHARGES, I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED.

Printed Patient Name

Signature (guardian if minor)

Date

ELECTRONIC CORRESPONDANCE APPROVAL

ELECTRONIC NEWSLETTERS OR OTHER ELECTRONIC MATERIAL MAY BE SENT TO MY E-MAIL ADDRESS(S).

_____ YES

_____ NO

_____ INITIALS

Mahalko Family Chiropractic

INFORMED CONSENT TO CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT: The doctor will use his/her hands to move your joints. You will typically feel and hear the movement of the joints similar to popping your knuckles. Therapeutic ice may be used.

POSSIBLE RISKS: You may feel tired after your first adjustment. You may feel sore like you “used muscles you didn’t know you had” like after your first workout at a gym. A very small percentage of people may feel pain, tingling, numbness, cramps or tightness in their extremities. There is a one in one million to one in ten million chance of stroke associated with certain types of cervical (neck) manipulation. We do not employ that type of procedure in our office. The risks of complications due to chiropractic care have been described as “rare”.

OTHER TREATMENT OPTIONS: Other treatment options which could be considered may include the following:

- Over-the-counter analgesics: The risks of these medications include irritation to the stomach, bleeding ulcers, liver and kidney damage, heart attacks, and other side effects in a significant number of cases.
- Medical Care: including prescribed anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable disease occurs in a significant number of cases.
- Surgery: in conjunction with medical care adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risk of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and include chronic pain cycles.

By signing below, I agree to the following: I have read the explanation above. I will have had the opportunity to have any questions answered to my satisfaction before beginning treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Printed Patient Name

Signature (guardian if minor)

Date