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_____

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.)

[ ] Headaches	[ ] Orthopedic Problems	[ ] Digestive Disorders	[ ] Behavioral Problems
[ ] Dizziness	[ ] Neck Problems	[ ] Poor Appetite	[ ] ADD/ADHD
[ ] Fainting	[ ] Arm Problems	[ ] Stomach Aches	[ ] Ruptures/Hernia
[ ] Leg Problems	[ ] Reflux	[ ] Muscle Pain	[ ] Heart Trouble
[ ] Constipation	[ ] Growing Pains	[ ] Back Pain	[ ] Seizures/Convulsions
[ ] Ear Infections	[ ] Diarrhea	[ ] Joint Problems	[ ] Allergies_____
[ ] Sinus Trouble	[ ] Poor Posture	[ ] Diabetes	[ ] Allergies_____
[ ] Asthma	[ ] Scoliosis	[ ] Hypertension	[ ] Allergies_____
[ ] Colds/Flu	[ ] Walking Trouble	[ ] Anemia	[ ] Other_____
[ ] Colic	[ ] Broken Bones	[ ] Bedwetting	[ ] Other_____

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

[ ] Fall in baby walker	[ ] Fall from bed or couch	[ ] Fall off skateboard	[ ] Fall off skates
[ ] Fall off swing	[ ] Fall from crib	[ ] Fall from highchair	[ ] Fall off bicycle
[ ] Fall down stairs	[ ] Fall from counter	[ ] Fall off monkey bars	[ ] Fall off slide
Other :	[ ] _____	[ ] _____	[ ] _____

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

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____ Other_____

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME APPOINTMENT REMINDERS.

_____ YES - BY PHONE

_____ YES - BY TEXT MESSAGE

_____ NO

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE A PHONE MESSAGE OR VERBAL MESSAGE WITH WHOEVER ANSWERS THE PHONE REGARDING APPOINTMENT INFORMATION OR CONCERNS REGARDING MY CARE.

_____ YES _____ NO

MAHALKO FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND NEWSLETTERS OR OTHER PRINTED MATERIAL TO ME VIA US MAIL OR OTHER SIMILAR METHODS.

_____ YES _____ NO

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

_____ YES _____ NO

MAHALKO FAMILY CHIROPRACTIC WILL PREPARE INSURANCE FORMS AND REPORTS IF YOU WISH TO FILE WITH INSURANCE. CASH PAYMENTS AND INSURANCE COPAYS 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

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