New Practice Member Application (Pediatric)

Name: _____ Date of Birth: ___ /___ /____ Age: _____ Male / Female

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

Guardian Name: _____ Relationship: _____

Phone Number: _____ Email: _____

Preferred Contact: Email / Text Message / Phone Call Weight: _____ Height: _____

Number of Siblings: _____ Names, Ages, & Gender: _____

_____

Whom may we thank for referring you? _____

Health Concerns That Brought You Into Our Office

Health Concerns Listed According to Severity:	Rate of Severity: 0 = No Pain 10 = Unbearable	When did this problem start?	Did the problem begin with an injury?	Are the symptoms constant (C) or intermittent (I)?
1.				
2.				
3.				
4.				

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

If Yes: Chiropractor / Medical Doctor / Other: _____

Who?: _____ When?: _____ Results?: _____

Please Mark "P" for Past and "C" for Current Health Concerns You Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Diabetes
___ 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	___ Scoliosis	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Growing pains	___ 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	___ Poor Posture	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Skin Problems	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Colic	___ Latching Issues

Pregnancy Information:

How was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy?: _____

Other information: _____

Delivery Information:

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

Birth Intervention (Circle One): None Forceps Vacuum Extraction Caesarian Section

Induced? Yes / No

If Yes, please explain below:

_____

Medications during delivery?_____

Other Information: _____

Post Birth Information:

Birth Weight: _____ Birth Length: _____

Breast Fed?: Yes / No How long? _____ Formula Fed?: Yes / No How long? _____

Introduced Solid Foods at _____ Months

Food Allergies or Intolerances: _____

Doses of antibiotics/prescription medications taken in the past 6 months: _____ Lifetime Total _____

Current medications/dosage: _____

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

_____

List all surgical operations & years: _____

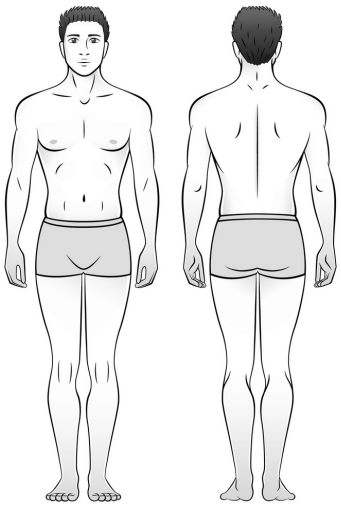
Has your child ever been knocked unconscious? Yes / No Fractured a bone? Yes / No

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

_____

Please Mark Areas on the Diagram with the Following Letters to Show Symptoms

A = Aching
D = Dull
R = Radiating
B = Burning
N = Numbness
T = Tingling
S = Sharp/Stabbing



Quadruple Visual Analogue Scale (QVAS)

Please circle the 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.

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?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

Daily Activities

Please circle how your current condition is affecting your ability to carry out activities of your daily life:

Activity:	**Effect:**			
0-2 Years Old				
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
Sleeping	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
3+ Years Old				
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	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
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

ACTIVITY	**CURRENT ACTIVITY LEVEL**	**GOAL ACTIVITY LEVEL**
Example: Sleeping	*Less than 1 hour straight*	*4-5 hours*

If This Health Profile is for a Minor/Child, Please Fill Out and Sign Below
Written Consent for a Child

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

I authorize Drs. Carson Wilde and Todd Beck and any and all Edified 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 Edified Chiropractic.

Name of Guardian: _____ Relationship: _____

Signature: _____ Date: _____

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 (HIPAA). 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 health care operations, such as quality assessments and physicians 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 health care 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.

Signature: _____ Date: _____

X-Ray Authorization

As your health care 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. 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 doctors of Edified Chiropractic do 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.

Signature: _____ Date: _____