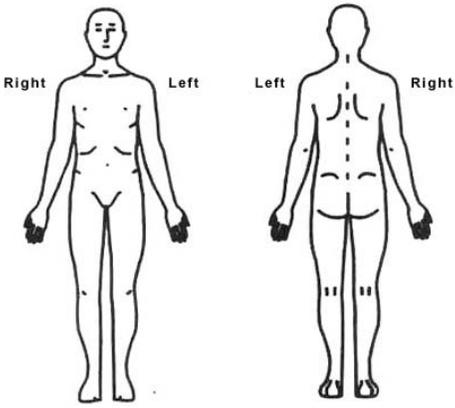


PEDIATRIC PATIENT INFORMATION

Child's Name:	Parent/Guardian Name:	Date: / /
Date of Birth: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:	Height: Feet Inches	
City:	State: Zip:	Weight: Pounds
Email:	Cell Phone: ()	Other Phone: ()
How did you hear about us:		
Name and location of your child's primary care physician:		
Is your child also receiving care from any other healthcare professional: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name & specialty:		

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?	
Has your child received care for this condition before: <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Please indicate where your child is experiencing pain or discomfort:</p> 
If yes, please explain:	
When did this condition(s) first begin: / /	
How did the problem start: <input type="checkbox"/> Gradually <input type="checkbox"/> Suddenly <input type="checkbox"/> Post-Injury	
Is this condition: <input type="checkbox"/> Getting worse <input type="checkbox"/> Improving <input type="checkbox"/> Staying the same	
How often are the symptoms present: <input type="checkbox"/> 0-25% <input type="checkbox"/> 25-50% <input type="checkbox"/> 50-75% <input type="checkbox"/> 100%	
Average pain intensity: No pain 1 2 3 4 5 6 7 8 9 10 Worst pain	
Current pain intensity: No pain 1 2 3 4 5 6 7 8 9 10 Worst pain	
What makes the problem better:	
What makes the problem worse:	

YOUR HEALTH GOALS

Your top 3 health goals for your child:

1. _____
2. _____
3. _____

LABOR & DELIVERY HISTORY

Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section

At how many weeks: _____ Doctor's/Obstetrician's Name: _____

Child's birth was at: Home Birthing center Hospital Other: _____

Please check any applicable interventions or complications:

Breech Induction Pain meds Epidural Vacuum extraction Forceps Other: _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: _____ lbs. _____ oz. Child's birth height: _____ in. APGAR score at birth: _____ At 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed: Yes No If yes, how long: _____ Difficulty with breastfeeding: Yes No

Did they ever use formula: Yes No If yes, at what age: _____ If yes, what type: _____

Did/does your child ever suffer from colic/reflux or constipation as an infant: Yes No If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head: Yes No If yes, please explain: _____

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____
Teethe: _____ Sit up: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food allergies and when they began: _____

Child's hospitalization & surgical history, including year: _____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule

If yes, please list any vaccination reactions: _____

Has your child received antibiotics: No Yes, please explain: _____

Behavioral, social or emotional issues: No Yes, please explain: _____

ACKNOWLEDGEMENT & CONSENT

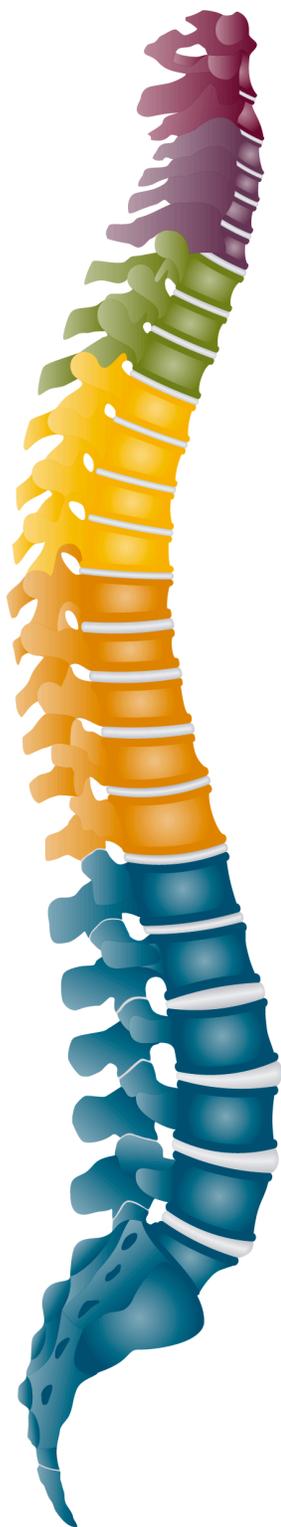
By signing below, I authorize Ascent Sports & Wellness Chiropractic Clinic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Ascent Sports & Wellness Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations. By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian's Signature _____ Date: _____

REVIEW OF SYSTEMS

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS					
		PAST	PRESENT				
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
	Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic at Ascent Chiropractic 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 doctors at Ascent Chiropractic, including those working at Ascent Chiropractic or any other office or clinic.

I understand and I am informed that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor.

I further understand that although spinal manipulations/adjustments, especially those techniques utilized at Ascent Chiropractic, are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is possible to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the doctor if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with caution.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Stroke: Although strokes happen with some frequency in our world, strokes associated with chiropractic adjustments are extremely rare. I am aware that nerve or brain injury including stroke is reported to occur once in one in ten million treatments. A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I further understand that Chiropractic adjustments and supportive treatments are 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 you 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 are not limited to 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.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian's Signature: _____ Date: _____