

# PEDIATRIC HISTORY FORM

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Name of Parents / Guardians: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Purpose for contacting us?** \_\_\_\_\_

Other Doctors seen for this condition:  No  Yes If yes, Doctors' names and Prior Treatments: \_\_\_\_\_

Other Health Problems? \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

- |   |   |                                       |   |   |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Chronic Colds    | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums  | <input type="checkbox"/> Other: _____         |

Family History Of Health Problems: \_\_\_\_\_

Previous Chiropractic care:  No  Yes Chiropractor name: \_\_\_\_\_

Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care your child has received there?  No  Yes

Number of doses of **Antibiotics** your child has taken:

During the past Six Months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

## Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications during pregnancy?  No  Yes List: \_\_\_\_\_

Ultrasounds during pregnancy?  No  Yes Number: \_\_\_\_\_

Medications during pregnancy / delivery?  No  Yes List: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy?  No  Yes

Location of birth:  Hospital  Birthing Center  Home

Birth Intervention:  Forceps  Vacuum Extraction  Caesarian Section: Emergency or Planned?

Complications during delivery?  No  Yes List: \_\_\_\_\_

Genetic Disorders or Disabilities?  No  Yes List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

### Feeding History:

Breast Fed:  No  Yes How long: \_\_\_\_\_

Formula Fed:  No  Yes How long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months, Cow's Milk at \_\_\_\_\_ months

Food / Juice Allergies or Intolerance:  No  Yes List: \_\_\_\_\_

### Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound: \_\_\_\_\_

Cross Crawl: \_\_\_\_\_

Respond to Visual Stimuli: \_\_\_\_\_

Stand Alone: \_\_\_\_\_

Hold Head Up: \_\_\_\_\_

Walk Alone: \_\_\_\_\_

Sit Up: \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?  No  Yes

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?  No  Yes List: \_\_\_\_\_

Has your child ever been involved in a car accident?  No  Yes List: \_\_\_\_\_

Has your child been seen on an emergency basis?  No  Yes List: \_\_\_\_\_

Other traumas not described above?  No  Yes List: \_\_\_\_\_

Prior surgery?  No  Yes List: \_\_\_\_\_

Menarche?  No  Yes Age: \_\_\_\_\_

### Childhood Diseases:

Chicken Pox:  No  Yes, Age: \_\_\_\_\_

Mumps:  No  Yes, Age: \_\_\_\_\_

Rubella:  No  Yes, Age: \_\_\_\_\_

Rubeola:  No  Yes, Age: \_\_\_\_\_

Whooping Cough:  No  Yes, Age: \_\_\_\_\_ Other:  No  Yes, Age: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# INTEGRITY

C H I R O P R A C T I C

Jeffrey K. Listiak, D.C.

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.
- **Vertebral subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

**All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.**

Therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

## PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. \_\_\_\_\_

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

## CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at Integrity Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- ❖ Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- ❖ Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of services provided to you.)
- ❖ Your name, address, telephone number, e-mail address and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, to advise you about health related meetings, workshops and products, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information to treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not at home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- ❖ If we provide health care services to you in an emergency.
- ❖ If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- ❖ If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- ❖ If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.



## CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below 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 doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is 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 not limited 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.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Name Printed of Guardian/Parental and Relationship to Patient: \_\_\_\_\_

Guardian/Parental Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor of Chiropractic Name: \_\_\_\_\_

Signature of Doctor of Chiropractic: \_\_\_\_\_

Date: \_\_\_\_\_

Your Appointment with Dr Jeff Listiak is on \_\_\_\_\_ at \_\_\_\_\_

120 Birmingham Dr Ste 100, Cardiff by the Sea CA 92007

760-230-2939

contact@integritychiropractic.info

Download your forms and fill out ahead of time at

[www.RestoreYourHealth.info](http://www.RestoreYourHealth.info)

Directions: Take I-5 to Birmingham exit, go west towards the ocean, at the bottom of the hill just before Jack in the Box, turn right into the Cardiff Executive Centre. Park in back on the upper level if possible. We are in Suite 100 at the western end of the building.

