Cura Integrative HEALTH CARE

Pediatric Form (<15 yoa)
Confidential Patient Information (Please Print)

Patient Information

Child's Name_____ Birth Date_____ Age_____ Date_____

Parent/ Guardian's Name _____ Home Phone _____

Address _____ Cell Phone_____

Parent Email Address_____ Height_____ Weight_____

Marital Status of Parents: ☐ M ☐ S ☐ W ☐ D

Would you like a text message reminder about your child's appointments? ☐ Yes ☐ No

Do you have out of network benefits that will contribute to Chiropractic care? ☐ Yes ☐ No

Name of Insurance Company_____ Policy Number _____

Policy Holder_____ Relationship to Patient _____ Date of Birth _____

Address_____ Phone_____

List any hobbies your child enjoys_____Who may we thank for referring you?_____

Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No

Name of the Office & Doctor_____ Were x-rays taken? ☐ Yes ☐ No

Who is your medical pediatrician? _____

Complaint History

What brings your child in today?_____ When did it start? _____

Does it happen at any specific time of the day? _____ Is it getting worse? _____

Does it affect daily activities? _____ What makes it better?_____

List care that your child has undergone for this complaint, including medication_____

General Health History

Prenatal History:

Any complications with pregnancy? When?_____ Is your child adopted? ☐ Yes ☐ No

Did you smoke or consume alcohol? ☐ Yes ☐ No

Did you take medication? ☐ Yes ☐ No Reason for the medication_____

Birth History:

Did you do regular ultrasounds? 3-D ultrasound? How many?_____

Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OBGYN ☐ Other_____

Type of Birth: ☐ Vaginal ☐ C-Section

What position did you deliver in? ☐ Squatting ☐ On Back ☐ Other_____

Were pain medications used? ☐ Yes ☐ No

Any Birth Trauma?

☐ Fractures ☐ Doctor assisted ☐ Twisting and/or Pulling ☐ Vaccum extraction ☐ Forceps

Was labor induced? ☐ Yes ☐ No If yes, why?_____

Newborn Trauma (medical procedures and tests)**:**

APGAR score: birth ___/10 5-minutes ___/10 ☐ Unsure

Did your child have a misshaped skull/head? ☐ Yes ☐ No Jaundice(yellow) at birth? ☐ Yes ☐ No

Were there purple markings on their face? ☐ Yes ☐ No Did you breast feed your child? ☐ Yes ☐ No

Does your child prefer one breast over the other? ☐ Yes ☐ No If yes, which side? ☐ Right ☐ Left

Does your child have any food allergies? ☐ Yes ☐ No If yes, please list:_____

Has your child been immunized? ☐ Yes ☐ No

Reason for vaccination? ☐ Informed Decision ☐ Recommended ☐ Didn't know I had a choice

Any negative reaction to vaccinations? ☐ Yes ☐ No Were they reported? ☐ Yes ☐ No

Has your child ever had any surgeries? ☐ Yes ☐ No If yes, please elaborate:_____

Has your child been on antibiotics? ☐ Yes ☐ No If yes, how often and what for:_____

Is your child currently taking any medication? ☐ Yes ☐ No If yes, what are they:_____

Is your child currently taking any vitamins? ☐ Yes ☐ No If yes, what are they:_____

Developmental History:

Please estimate at what age did the following occur:

Respond to sound_____ Crawl_____ Follow object with eyes_____

Hold Head Up_____ Stand_____ Sit Alone_____

Walk Alone_____ Chicken pox_____ Rubella_____

Whooping cough_____ Mumps_____ Measles_____

Other_____

Baby/Toddler (0-4):

Have any of the following occurred:

☐ Fall where the child hit their head (off changing table, out of crib, off playground equipment, down stairs)

☐ Frequent Crying Spell ☐ Fall down the Stairs ☐ Motor-Vehicle Accident ☐ Play in Johnny Jumper

☐ Frequent Ear Infections ☐ Tonsillitis ☐ Frequent Fevers ☐ Frequent Diarrhea

☐ Constipation ☐ Sleeping Problems ☐ Repeated Infections ☐ Colic

☐ Anemia ☐ Blood Disorders ☐ Heart problems ☐ Problems walking/crawling

☐ (+ or -) weight ☐ Other_____

Child (5-12):

Have any of the following occurred:

☐ Fall from a tree	☐ Fall off a bicycle	☐ Sports Accident	☐ Stomach Pains
☐ Hyperactivity/Autism	☐ Scoliosis	☐ Bedwetting	☐ Learning difficulties
☐ Asthma/Allergies	☐ Leg/Knee Pains	☐ Motor-Vehicle Accident	☐ Fall on Playground
☐ Behavior Problems	☐ Broken bones	☐ Diabetes	☐ Muscle Jerking

Which of the above bothers your child the most?_____When did it begin? _____

Is it getting worse? _____ Is the pain: ☐ Constant ☐ Intermittent

Does the pain affect your child's activity? Which activities?_____

Does your child participate in any of the following:

☐ Soccer	☐ Football	☐ Hockey	☐ Wrestling	☐ Swimming	☐ Lacrosse
☐ Baseball	☐ Softball	☐ Rugby	☐ Gymnastics	☐ Basketball	☐ Volleyball
☐ Karate	☐ Dance	☐ Tennis	☐ Other_____		

How would you rate your child's diet? ☐ Well Balanced ☐ Average ☐ High Sugar/Processed Foods

Does your child consume artificial sweeteners? ☐ Yes ☐ No Fluoridated water? ☐ Yes ☐ No

Number of hours your child sleeps per night? _____ Quality? ☐ Good ☐ Fair ☐ Poor

AUTHORIZATION TO TREAT A MINOR

I, _____, the undersigning parent/guardian, having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Cura Integrative to perform in judgement any treatment, physical examination, X-ray studies, laboratory procedures AND chiropractic diagnosis or treatment which is deemed necessary. I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand that the doctor is prohibited from selling any part of my medical record.

INSURANCE & PAYMENT INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in out-of-network collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, and attorney's fees in addition to above fees. I also understand that all payments for services rendered are due at the time of service. All fees for professional services rendered to me are immediately due and payable.

Date_____

Parent/Guardian's Signature_____

NUTRITIONAL INFORMED CONSENT

I hereby attest to the following:

I fully understand that the Nutritional Consult I am seeking in this office is not a physician and I am not consulting for medical, diagnostic, or treatment procedures. The services provided are at all times restricted to helping me gain a better understanding of my degree of health, not disease, so that I may have a greater sense of awareness of my health and wellbeing.

I understand that and course of care pertains to the whole body concept of nutrition and does not relate in the context of a particular ailment of medical condition. There is no diagnosing, treating, prescribing of medicines or drugs for the treatment of disease, or any act that will constitute the practice of medicine in this state.

According to the Federal Food, Drug and Cosmetic Association, as amended, Section 201 (g) (1), the term “Drug” is defined to mean:

> “Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A vitamin is not a drug. Neither is a mineral, trace element, amino acid, essential oil, herb, or homeopathic remedy.

Although a vitamin, mineral, trace element, amino acid, essential oil, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can me misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary guidance is not intended as a primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional Counseling, vitamin supplementations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good, proper nutrition that will support the physiological and bio-mechanical processes of the human body. Nutritional intake may enhance the stabilization of the eight chemical components of the vertebral subluxation complex and the energy movement in Traditional Chinese Medicine. These homeopathic, whole food supplements are not medications and do not have the shelf life of pharmaceuticals. Due to this decreased shelf life and also to sensitivity of supplements to temperature and sunlight, there will be no returns or refunds on supplements purchased.

Signed: _____ Date: _____

Print Name: _____