Birks Chiropractic & Wellness Center

Pediatric New Patient Health History Form

Dr. Kara Birks, DC Dr. Linda Claeys, DC Dr. Ariel Young, DC

Patient Data

First Name:_____ Last Name: _____Today's Date: _____
Address: _____ City: _____ State:_____ Zip:_____
Mother's Name: _____ Mother's Employer: _____
Father's Name: _____ Father's Employer: _____
Mother's Phone: _____ Father's Phone: _____
Birth Date: _____ Sex: _____F _____ M
How were you referred?
_____

The Birth

Age of Patient: _____ yrs _____ months Birth Weight: _____ Birth Length: _____
Current Weight: _____ Current Length:_____
Was the Birth: ____ Normal _____ Breech _____ Cesarean _____Home Birth _____ Vacuum Extraction _____ Forceps
Where was the Birth: _____
Any pregnancy problems:_____
_____
Congenital (Birth) Defects/Anomalies_____
_____
Was there Presence at Birth: _____ Meconium ____ Cyanosis(Blue) ____ Jaundice (yellow)
Pediatrician/Family MD _____
Obstetrician/Midwife _____
Date and Purpose of Last MD Visit: _____
Has this Child Been Treated for an Emergency? ____ Yes ____ No Describe_____
_____
Surgeries_____
Traumas:_____
Medications and Vitamins:_____
Accidents (Even Minor): _____
_____
Has the child been hospitalized: _____
Have this child ever been under chiropractic care? NO ____ YES ____
What are the current symptoms you are seeking treatment for :_____
_____

In order to provide you the best possible wellness care, please complete this form.
All information is strictly CONFIDENTIAL.

____ Allergies	____ Heart Troubles
____ Anemia	____ High Blood Pressure
____ Arthritis	____ Hyperactivity
____ Asthma	____ Irregular Heartbeat
____ Arm Problems	____ Joint Problems
____ Backaches	____ Leg Problems
____ Bed Wetting	____ Muscle Jerking
____ Bronchitis	____ Neck Problems
____ Behavior Problems	____ Neuritis
____ Cancer	____ Orthopedic Problem
____ Constipation	____ Paralysis
____ Convulsions	____ Poor Appetite
____ Diabetes	____ Rheumatic Fever
____ Digestion Problems	____ Ruptures/Hernias
____ Dizziness	____ Sinus Trouble
____ Earaches	____ Sleep problems
____ Fainting	____ Spinal Curvatures
____ "Growing Pains"	Other
____ Headaches	_____

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Family Member: (ie.mother, father)	Condition:
_____	_____
_____	_____
_____	_____
_____	_____

I CERTIFY THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

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Informed Consent for Care

You are the decision maker for the health care of your child. This informed consent involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, the potential effect on your child's health if you choose not to receive the care and any of the fees for the services being provided to your child by Birks Chiropractic and Wellness Center S.C..

Chiropractic care involves what is known as a chiropractic adjustment and possible additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing pain, swelling and inflammation in a joint, and improving neurological function and overall well-being. We may conduct chiropractic, physiotherapy, acupuncture, diagnostic or examination procedures if indicated that will be carefully performed but may be uncomfortable.

It is important you and your child understand, as with any health care approach, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burn and/or scarring from electrical stim or cold therapies, broken bones, disc injuries, dislocations, strains and sprains and strokes.

With respect to stroke, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing and driving. Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients, who experience the condition often, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1 million to 1 in 2 million cervical adjustments.

It is also important that you understand that there are treatment options available for your child's condition other than chiropractic procedures. Likely, you have tried many of these approaches already and have the right to a second opinion about your child's circumstances and health care as you see fit.

I understand that if my child is accepted as a patient by Birks Chiropractic and Wellness Center S.C., I have read, or have had read to me, the above consent. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to my child and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment for my child, any fees for professional services rendered to my child will be immediately due and payable. I understand I am financially responsible for all services rendered to me or my dependent at Birks Chiropractic and Wellness Center SC. I hereby authorize Birks Chiropractic and Wellness Center SC to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for the remaining balance. I further authorize my insurance company to direct payment to Birks Chiropractic and Wellness Center SC on my behalf. I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan. I understand that results are not guaranteed. I am authorizing them to proceed with any treatment that may be necessary for my child. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care for my child is deemed appropriate for any circumstance for which I seek chiropractic care for my child from Birks Chiropractic and Wellness Center S.C..

I hereby authorize Dr. Kara Birks, DC, Dr. Linda Claeys, DC and Dr. Ariel Young, DC and whomever they may designate as an assistant to examine and administer treatments as deemed necessary to my child, _____.
Printed name of person authorizing treatment: _____
Signature: _____
Date: _____ Relationship to Child: _____

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