We want to know about your child! (Confidential)

Name: _____DOB: _____/_____/_____ Gender_____

Home Address _____City_____State_____Zip_____

Name(s) and age(s) of siblings_____

Parent(s)/Guardian (s) Name(s)_____

Parent (s)/Guardian (s) Phone (Home) _____(Work/Cell) _____

Email _____

Emergency Contact: _____ Phone # (_____)_____

Who can we thank for referring you to Elements of Being?

Previous Chiropractic Care? Y/N Date of last adjustment_____Name of Chiropractor_____

Have you consulted any other health care practitioners for this reason? Y/N If Yes, Who: _____

Third trimester presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/brow

Type of birth: ☐ Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap or Vacuum **Weeks of Gestation at birth** _____

Silver nitrate drops? Y/N ☐ **Incubation?** Y/N ☐ f yes, how long? _____

Location: ☐ Home ☐ Birthing Center ☐ Hospital **Chemical Induction?** Y/N **Epidural?** Y/N

Problems during pregnancy: _____

Problems during labor/delivery: _____

Apgar scores: _____ _____**Was there presence at birth of:** ☐ Jaundice (yellow)? ☐ Cyanosis (blue)?

Congenital anomalies/defects (if yes explain)? _____

Infant feeding: ☐ Breast ☐ Formula **Number of sleeping hours per night** _____ **Quality?** ☐ good ☐ fair ☐ poor

During the pregnancy process, did mother:

Take medications? Y/N Type: _____**Experience any illness?** Y/N Type: _____

Undergo undue stress? Y/N if yes, explain_____

Receive ultrasounds or other radiation? Y/N ☐ **Smoke or consume alcohol or drugs?** Y/N ☐

Obstetrician/Midwife: _____**Pediatrician**_____

Vaccination History: _____

Number of doses of antibiotics your child has taken: During last 6 mos _____**During his/her lifetime**_____

At what age did you child:

Respond to sound _____ **Follow an object with his/her eyes** _____ **Hold head up** _____

Sit alone _____ **Crawl** _____ **Stand** _____ **Walk alone** _____

Has your child ever suffered from?:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic ear aches
- ☐ Sinus trouble
- ☐ Colds/flu
- ☐ Colic
- ☐ Asthma
- ☐ Orthopedic problems
- ☐ Neck problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Joint problems
- ☐ Backaches
- ☐ Poor posture
- ☐ Scoliosis
- ☐ Broken bones
- ☐ Walking trouble
- ☐ Digestive disorders
- ☐ Poor appetite
- ☐ Stomach aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed wetting
- ☐ Behavioral problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing pains
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Allergies to _____
- ☐ Other_____
- ☐ Other _____

Has your child ever suffered from the following spinal traumas?

- ☐ Fall off baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard of skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other_____

Has your child ever sustained an injury playing organized sports? Y/N ☐ **If yes, please explain:** _____

_____

Has your child ever sustained injuries in a car accident? Y/N ☐ **If yes, please explain**: _____

_____

Present history/complaint: _____

_____

_____

Surgeries: _____

Medications: _____

Accidents: _____

Family history: _____

Anything else relevant: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, 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 a 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 dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, 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 one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. 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 as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature:_____ Date:

24 Hour Appointment Cancellation Policy:

Elements of Being Family Chiropractic is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call or text us at (415) 497-4546 at least 24 hours prior to your scheduled appointment to notify us of any changes or cancellations.

If prior notification is not given, you may be charged for the missed appointment, unless otherwise considered by Kacie Flegal, D.C.

Please sign below to consent to these terms.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Date