

Schneider
Chiropractic
& Wellness

Date: ___/___/___



Note: Please answer all questions. If it does not apply, please write n/a (for not applicable).-- Thank you!

Regarding Children: My responsibility as your Chiropractor is to examine and evaluate your child's spine for the presence of "vertebral subluxation".
(Vertebral subluxations are spinal mis-alignments that alter nervous system function & limit the full expression of health, growth and normal development).

Child's name: _____ Age: _____ DOB: ___/___/___

Parents/ guardian name(s): _____ Relationship: _____

Address: _____ Town _____ Zip _____

Phone #'s : home: _____ Cell: _____ Work: _____

About the pregnancy:

Did you carry to full term? Y N explain: _____

Describe any pregnancy/delivery complications : _____

Did you use: a midwife? Hospital? Obstetrician? Delivery by C section?
Did they use: forceps / vacuum extraction Epidural Induced labour
Was it a difficult birth? Y N. Explain: _____

What was the baby's **APGAR** Score at delivery? ___ and at 5 minutes? _____

During your pregnancy:

Did you breastfeed? Y N How long? _____ What formula after? _____

Did you drink alcohol? Y N Did you smoke? Y N

Did you use any medications (even over the counter) Y N

Which/for what? _____

Was your child exposed to ultrasounds? Y N How many times? _____

Is your child **vaccinated**? Y N . All required not-vaccinated by choice

Any **reactions** to any of the vaccinations noticed? Y N If yes, what reaction and to which vaccination? _____

Were you told that you had a **choice** in vaccinating your child? Y N

(If you would like more information about vaccinations, visit our web site and enter "vaccination" in our article search box.)

Has your child been **hospitalized** for any reason? Y N Explain: _____

Please note here if your child was **seen by any other healthcare providers** for this problem(s) & by whom? _____

Has your child **fractured** any bones, had any major falls or been involved in a

motor vehicle accidents? Y N Explain: _____

Treated with **antibiotics** how many times? _____. For what? _____

Is your child currently taking any **medication** at all, including over the counter meds? Y N . If yes, explain: _____

Injuries, trauma, health issues: please note major or recurring issues.

From birth to 3 years of age, did any of the following occur? **P=past C=currently**

- | | |
|-----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Frequent crying spells/colic |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> Fall off playground equip. | <input type="checkbox"/> Frequently constipation |
| <input type="checkbox"/> Played in Jolly Jumper | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Did not gain weight | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Reaction to vaccination | Illness: _____ |
| <input type="checkbox"/> Depression/anxiety | Other: _____ |

Please explain the above: _____

From age 4-18 years of age did any of the following occur? **P=past C=currently**

- | | | |
|--------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting/bladder issues | |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Stomach/digestive issues | |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Upper resp. infections | |
| <input type="checkbox"/> Sports injury | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Hyperactivity/Autism | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Ear infections | |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness: arms/legs | <input type="checkbox"/> Pain: arms/legs |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in arms/legs | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder/hip pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Growing Pains: where _____ | |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Chronic illness (diabetes,etc.): _____ | |

Please explain any of the above: _____

***If your child was **adopted**, please include any relevant information here: _____

Please note below any current symptoms or conditions that are of primary concern:

1. **Problem:** _____ Started when? _____
How often it occurs: Constant Occasional Cyclical
What makes it worse: _____ Better? _____
What have you tried up to now that hasn't worked: _____

How does it affect his/her behavior/quality of life? _____

How does it affect the family situation: _____
_____.

2. **Problem:** _____ Started when? _____
How often it occurs: Constant Occasional Cyclical
What makes it worse: _____ Better? _____
What have you tried up to now that hasn't worked: _____

How does it affect his/her behavior/quality of life? _____

How does it affect the family situation: _____
_____.

Any other health concerns? _____
_____.

AUTHORIZATIONS

I, the undersigned, authorize Dr. Bruce Schneider to provide Chiropractic care to my minor dependent(s). I, the undersigned, authorize release of any medical information or other information necessary to process insurance claims for my minor dependent(s). I also request that payment of authorized insurance benefits be made, for my child or on their behalf, to Schneider Chiropractic (if they take assignment of benefits) for any services furnished by Dr. Schneider or staff. I'm responsible for an unpaid balance on this account. I authorize any holder of medical information about my children to release to my insurance carrier and/or Medicare and its agents any information needed to determine these benefits payable for related services. I also give Schneider Chiropractic permission to obtain my children's records from their insurance company, attorney(s), or any of their doctors or hospitals/clinics as needed. I am giving written permission for Dr. Bruce Schneider to make healthcare decisions regarding the Chiropractic care my children will receive since I, the parent/legal guardian listed below may not be present at all of his/her scheduled visits. I understand that I or another parent/legal guardian will and must be present for my child's first appointment. I also understand this signed consent will be valid until the minor child is 18 years of age, or unless I withdraw this permission in writing. When the child is no longer a minor, this authorization will still be in place unless the child, now an adult, withdraws this permission in writing. I also acknowledge that I have read and understand this office's HIPAA policy document & was offered a copy of it. I realize that I may elect not to keep a copy of it, knowing that it I can elect to download it from the office web site. I attest to the fact that all the information provided on this form is accurate & truthful and that I have read and understand all the stated policies noted in this document. The Doctor and I (legal parent/guardian) have adequately discussed the risks involved with treatment that are specific to my child's (or children's) conditions & other treatment options. I have also provided the above information freely and accurately. I present my child/children today for no other reason other than evaluation and treatment. Legal guardian name: _____ Signed: _____
Relationship to child: father mother guardian* _____.