BACK TO BALANCE CHIROPRACTIC

Children's Case History

Welcome to our Office! This information will help us serve you better.
Thank you for trusting us with your health.

Name:	Date:
Address:	Home Phone:
City/State/Zip:	
Social Security #:	Cell Phone:
Birth Date:	Age:
Parents names:	
Parents work #:	
Email:	
In case of Emergency who may we contact: Name:	Phone:

CAUSE

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Who may we thank for referring you?

Purpose of this visit: (Please describe your condition, concerns, and all health related issues).

What do you believe is wrong?

Date present condition began? _____ How?

Have you had previous Chiropractic Care? _____ Who:

Have you had these complaints before? _____ If so when?

Previous Surgeries/Hospitalizations:

Current Medications:

Who is your Primary Medical Physician?

Have you ever had a serious illness? _____ Please describe diagnosis and treatment.

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According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child?____
Please Describe:_____
Any fractures or dislocations?_____

Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other_____.

Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? _ _yes ___ no. Is it in front of a computer or TV?_____

How would you rate your child's diet?_____
Does your child consume artificial sweeteners?_____ _Fluoridated water?_____

Circle any of the following conditions your child has suffered from :
Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other_____
_____

How often has your child been treated with drugs ? _____
Were you informed of their adverse reactions ? ____yes____ no
If it was an antibiotic, was your child cultured for its use?_____
Is your child currently on any medications? (please list) _____
Any surgeries?_____

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child?
Did your child experience any behavioral , emotional or physical changes within 3 months after any shots?____
Describe_____
Was it reported by you or your doctor?_____

Have there been any significant stresses in your life lately? (e.g. deaths, divorce, family, work) _____

Do you participate in regular exercise? _____

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Patient Name:_____ File #:_____ Date:_____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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 below or any other office or clinic.

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 other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disk 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 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name _____ Name of Representative _____

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

Translated by _____ Date _____

Name of Doctor's treating this patient:

Amber Bush, D.C. - CA License # 29980

Patient Name:_____ **File #:**_____ **Date:**_____

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*Patient name:*_____ *File #:*_____ *Date:* _____

Office Visit Consent Form

I/ We the undersigned guardian(s) of:_____
(Childs name)

I/ we hereby give permission to the following relatives and/ or caregivers to bring my/ our child to his/her chiropractic appointment(s):

Name	Relationship to Child

Emergency Names and Numbers

1. Name_____ Phone:_____
   Relationship to child:_____

2. Name_____ Phone:_____
   Relationship to child:_____

3. Name_____ Phone:_____
   Relationship to child:_____

Name/Legal Guardian Signature:_____
Relationship to child:_____
Date:_____

Patient Name:_____ **File #:**_____ **Date:**_____

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