197 W. Cherry Ave
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www.BackToBalanceChiro.net

Pediatrics' Case History

Child's Name_____Birthdate_____Sex_____

Address_____City_____Zip_____

Parents' Names_____

Home Phone_____ Parent's Work/cell #_____

Siblings and ages _____

_____

Who may we thank for referring you to our office?_____

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.

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic?____Who?_____
Were x-rays taken?_____. Who is your regular pediatrician?_____

2. Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

Did you have ultrasound during this pregnancy?_____ Frequency_____

- Place of birth: Home/ Birthing Center/ Hospital .
- Provider: Midwife/ OB-Gyn/ Other_____
- Type of Birth: Vaginal / C-section. Was anesthesia used?_____ Type_____
- Was labor induced?_____ If yes, why?_____
- What position did you deliver in: Squatting/ On Back
- Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps
- Newborn trauma (medical procedures and tests)_____

3. Did you breast-feed your child? _____yes _____ no. How long?_____
Was your decision supported by your health care provider? ___yes___no.
Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

4. 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?_____

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

6. 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?_____

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

8. 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_____
_____

9. 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?_____

10. 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?_____

Correction

Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION FOR CARE OF A MINOR

I hereby Authorize Dr. _____ to administer care as deemed necessary to my son/daughter.

Signed_____Date_____

Witnessed_____ Date_____

AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS

I, _____, authorize Dr. _____or another person authorized by him/her to take and publish photographs of my child, _____, for clinical records. Such photographs may be used in publications for the purpose of scientific and /or clinical research, chiropractic education, and the promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization.

DATE: _____
SIGNED: _____
WITNESS: _____

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:* _____

Dr. Amber Bush
197 W. Cherry Ave ● Porterville, CA 93257 ● Ph: 559.783.2225 Fax: 559.788.2225

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:_____