Prosperity Chiropractic

Pediatric New Practice Member Application

Name _____ Date of Birth _____ /_____ /_____ Age _____ Male / Female
Address _____ City _____ State _____ Zip _____
Guardian(s) Name _____ Relationship _____
Phone Number _____ Weight _____ Height _____
Who may we thank for referring you? _____

List the Health Concerns That Brings Your Child into Our Office

Health Concerns Rate the severity of stress causes in your life Problem begin? When did this Problem before? Have you had this Constant (C) or Are your symptoms (0=none, 10=unbearable) (List according to severity) this Intermittent (I)

Primary _____ _____ _____ _____ _____

Second _____ _____ _____ _____ _____

Third _____ _____ _____ _____ _____

Fourth _____ _____ _____ _____ _____

Have you ever seen other doctors for these conditions? □ Yes □ No
If Yes: □ Chiropractor □ Medical doctor □ Other_____ Who?
_____ When? _____ Results? _____

Please Mark "P" For in the Past OR Mark "C" For Currently Have

___ Headaches ___ Ear Infections ___ Sinus Issues ___ Kidney Problems ___ Migraines ___ Hearing Loss ___ Frequent Colds ___ Bladder Problems ___ Sleep Problems ___ Diabetes ___ Jaw/TMJ Pain ___ Ringing in the Ears ___ Thyroid Issues ___ Seizures ___ Tight/Sore Muscles ___ Neck Pain ___ Dizziness ___ Asthma ___ Scoliosis ___ Sports Injury ___ Shoulder Pain ___ Loss of Energy ___ Chest Pain ___ Stomach Problems ___ Sciatica ___ Arm Pain ___ Nervousness ___ Heart Problems ___ Fibromyalgia ___ Joint Pain ___ Upper Back Pain ___ Double/Blurry Vision ___ Nausea ___ Epilepsy/Convulsions ___ GERD/Gastric Reflux ___ Mid Back Pain ___ Anxiety ___ Ulcers ___ Tremors ___ Numb/Tingling in Arms/Hands ___ Lower Back Pain ___ ADD/ADHD ___ Digestive Issues ___ Disc Problems ___ Numb/Tingling in Legs/Feet ___ Hip/Leg Pain ___ Loss of Balance ___ Diarrhea ___ Scoliosis ___ Difficulty Breathing ___ Knee Pain ___ Depression ___ Constipation ___ Poor Posture ___ Growing pains ___ Foot Pain ___ Allergies ___ Bed Wetting ___ Skin Problems ___ Torticollis

Other:_____

Pregnancy + Fertility History:

Any fertility issues? □ Yes □ No If yes, explain: _____ Did mother smoke? □ Yes □ No If yes, how many times per week? _____ Did mother drink? □ Yes □ No If yes, how many times per week? _____ Did mother exercise? □ Yes □ No If yes, explain: _____ Was mother ill? □ Yes □ No If yes, explain: _____

Any ultrasounds? □ Yes □ No If yes, how many? _____ Please explain any notable episodes of mental or physical stress during the pregnancy:

_____

Please explain any other notable remarks about your conception or pregnancy with your child:

_____

Labor + Delivery History:

Child's birth was: Natural Vaginal Birth Scheduled C-Section Emergency C-Section Location of birth: Home Birth Center Hospital Other: _____ At how many weeks was your child born? _____ Circle any applicable interventions or complications:

Breech Forceps Vacuum Extraction Induction Pain Meds Epidural Pitocin Episiotomy Other information:

_____ Birth Weight: _____ lbs. _____ oz. Birth Length: _____ in.

APGAR Score at Birth: _____ APGAR Score After 5 Minutes: _____

Growth + Development History:

Breastfed: □ Yes □ No How long? _____ Formula fed □ Yes □ No How long? _____ Difficulty breast feeding: □ Yes □ No Introduced solid foods at _____ months Did / does your child suffer from colic, reflux, or constipation as an infant? □ Yes □ No

If yes, please explain: _____

Did / does your child frequently arch their neck / back, feel stiff, or bang their head? □ Yes □ No If yes, please explain: _____ Have you chosen to vaccinate your child? □ No □ Yes, on a delayed schedule □ Yes, on schedule If yes, please list any vaccine reactions: _____ Has your child received any antibiotics? □ Yes □ No If yes, how many times? _____ If yes, for what reasons? _____ Food allergies / intolerances and when they began: _____

List all hospitalizations and surgical operations, including the year:

_____

List any major accidents, falls, head injuries, or fractured bones your child has sustained in their lifetime, including the year:

_____

Night terrors or difficulty sleeping? □ Yes □ No If yes, explain: _____ Behavioral, social, or emotional issues? □ Yes □ No If yes, explain: _____ How would you describe your child's diet? □ Mostly whole, organic foods □ High amounts of processed foods □ Average At what age did your child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____ Sit alone: _____ Crawl: _____ Walk: _____

Activities of Life (Ages 0-2 years)

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY: EFFECT:

Holding Head Up □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Tummy Time □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Nursing □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Sitting Up □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Crawling □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Standing Alone □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Walking Alone □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Other: _____ □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Other: _____ □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Activities of Life (Ages 3-12 years)

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY: EFFECT:

Stand □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Sit □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Walk □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Run □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Exercise / Play □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Chores □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Play Sports □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Read □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Sleep □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform Other: _____ □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Other: _____ □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform List your Top 3 Health Goals for your child:

1. _____
2. _____
3. _____

What are you hoping to gain from chiropractic care? □ Resolve existing condition □ Overall wellness □ Both

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked, 0=no pain and 10=unbearable. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW?

   0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

   0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at BEST?

   0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST?

   0 1 2 3 4 5 6 7 8 9 10

Practice Member Name (child): _____ Date: _____

For A Minor/Child Guardian, Please Fill Out and Sign Below

Written Consent for a Child

Name of practice member who is a minor/child: _____ I authorize Dr. Rileigh Muse DC and any and all Prosperity Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is
revoked or altered, I will immediately notify Prosperity Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to Minor / Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications. I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Prosperity Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____