



ZAO CHIROPRACTIC PEDIATRIC HEALTH PROFILE

Name _____ Date of Birth ____/____/____ Age _____ Male / Female

Address _____ City _____ State _____ Zip _____

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

Phone Number _____ Siblings _____

Height _____ Weight _____

Office Only _____

Pediatrician/Family MD _____ City/State _____

Last Visit: ____/____/____ Reason for visit: _____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW:

Table with 6 columns: Health Concerns, Rate of Severity, When did this episode start?, If you had the condition before, when?, Did the problem begin with an injury?, Are symptoms constant or intermittent? Rows 1-5.

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor? _____ Medical Doctor? _____ Other _____

Who and When? _____

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE:

- ___ HEADACHE/MIGRAINE ___ HEARING LOSS ___ LOSS OF ENERGY ___ LOSS OF BALANCE
___ EAR INFECTIONS ___ SLEEP PROBLEMS ___ POOR POSTURE ___ BACK/NECK PAIN
___ SCOLIOSIS ___ EATING PROBLEMS ___ TEMPER TANTRUMS ___ BLADDER PROBLEMS
___ ADD/ADHD ___ GASTRIC REFLUX ___ ANXIETY ___ DIGESTIVE PROBLEMS
___ BED WETTING ___ ANXIETY ___ FREQUENT COLDS ___ HEART PROBLEMS
___ DEVELOPMENTAL DELAY ___ DEPRESSION ___ DIABETES ___ KIDNEY PROBLEMS
___ GROWING PAINS ___ NERVOUSNESS ___ LEG/ARM/JOINT PAIN ___ THYROID PROBLEMS
___ SCOLIOSIS ___ CONSTIPATION ___ JAW PAIN ___ SPORTS INJURY
___ SEIZURES ___ DIARRHEA ___ ULCERS ANY KNOWN DIAGNOSES ___
___ SINUS ISSUES ___ NAUSEA ___ RINGING IN THE EARS
___ ASTHMA ___ ALLERGIES ___ DOUBLE/BLURRY VISION
___ COLIC ___ SKIN PROBLEMS ___ DIZZINESS

Pregnancy Information

Briefly describe your pregnancy _____

Any pregnancy complications? _____

Any drugs/medication during pregnancy? _____

Other information _____

Delivery Information

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section None

Induced Labor? YES / NO

If yes, please explain _____

Medications received during delivery _____

Other information _____

Post Partum Information

Birth Weight _____ Birth Length _____ APGAR SCORE _____

Breast Fed? YES / NO How long? _____ Formula Fed? YES / NO How Long? _____

Age Introduced to Solid Foods _____

Food Allergies or Intolerances _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months _____ Total lifetime _____

Current prescription medication/dosage? _____

Over the counter medication (Tylenol, cough syrup, laxatives, etc.)

List all surgical operations & years _____

Trauma Information

Has your child ever been knocked unconscious? YES / NO Fractured A Bone? YES / NO

If yes to either, please describe _____

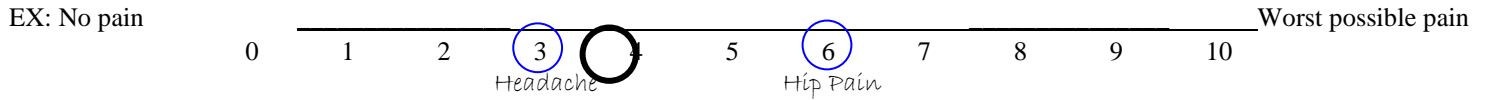
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? YES / NO

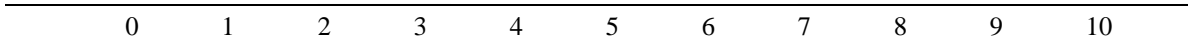
Explain _____

Quadruple Visual Analogue Scale

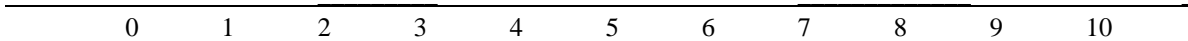
Please circle the number that best describes the question asked. If there is more than one condition, please answer each question for each individual complaint and indicate the score of each complaint.



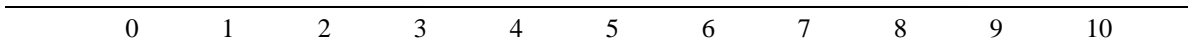
1. How would you rate the symptom/pain RIGHT NOW?



2. What is the typical or AVERAGE of the symptom/pain? (How bad is the symptom/pain throughout most of a day?)

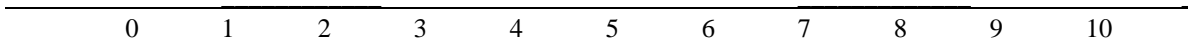


3. What is the symptom/pain level at its BEST? (How close to 0 does the symptom/pain get at its best?)



What percentage of awake hours is the symptoms/pain at its best? _____%

4. What is the symptom/pain level at its WORST? (How close to 10 does the symptom/pain get at its worst?)



What percentage of awake hours is the pain at its worst? _____%

Activities of Life

Please identify how your child's ability to carry out activities that are routinely part of life are affected by current condition

ACTIVITIES:

EFFECT:

Holding Head Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Tummy Time	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Nursing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Crawling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Standing Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Walking Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Difficult/Painful	<input type="checkbox"/> Limited/Very Painful	<input type="checkbox"/> Unable to Perform

LIST RESTRICTED ACTIVITY

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

Medical Information Release Form

Name _____ Date of Birth ____/____/____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

- Spouse _____
- Children _____
- Other _____
- My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call my home my work my mobile number _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- _____

Parent/Guardian Signature

____/____/____
Date

Authorization for Use or Disclosure of Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Zao Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images and/or testimonial will be used for: *In-office material, Merchandise, Social Media and/or Advertising*

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Treatment Conditions:

I understand that the practice cannot and will not condition treatment based on whether or not I sign this authorization.

Parent/ Guardian _____

Date _____

Signature _____

Office Only _____

Date _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH UPPER CERVICAL ADJUSTMENT IS EXTREMELY REMOTE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE

DATE

IF PRACTICE MEMBER IS A MINOR/CHILD(UNDER THE AGE OF 18), PARENT OR GUARDIAN MUST SIGN BELOW.

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

DATE

RELATIONSHIP TO MINOR/CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE