Pediatric Health History

Great Lakes Chiropractic
12000 Elm Creek Blvd. Ste L70
Maple Grove, MN 55369
Phone 763-420-4635 Fax 763-390-1381

Date: ___________________ Child's Name: ____

SS# of Guardian (please indicate father/mother): ____

DOB: __________________ Grade In School: ______ Sex: ______ Home Phone: _________________________

Address: ________________________________ City: ________________________ State: _____ Zip: ________

Mother's Name: ________________________________ Cell/Work Phone: _______________/_______________
First **Last**

Father's Name: ________________________________ Cell/Work Phone: _______________/________________
First **Last**

Purpose of this
appointment: ____

____

____

Pregnancy History (Mother)
(If the child is adopted, answer to the best of your ability)
Did you ever experience any of the following during your pregnancy:

___ Severe viral infection during the first trimester
___ Breech position during pregnancy
___ Accident or infections
___ Smoking
___ Severe stress
___ Pre-eclampsia
___ Alcohol consumption and/or drug use
___ Radiation exposure
___ Hypertension (high blood pressure)
___ Toxoplasmosis
___ Uncontrolled Diabetes
___ Toxemia

Labor and Delivery History
Did you and/or the child experience any of the following during the labor/delivery:

___ Hospital birth
___ Birthing home
___ Long and/or difficult labor
___ Placenta previa
___ Forceps or vacuum
___ Fetal distress
___ Elective c-section
___ The child was a "blue baby"
___ Home birth
___ The labor was induced
___ The delivery was rapid
___ Breech birth
___ Cord around neck
___ Emergency c-section
___ The child was premature (2+ weeks)
___ Medications during delivery. If yes, list (i.e. epidural)_________________
____

Comments:____

____

____

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Newborn History
Did the child experience any of the following as a newborn:

___ Required resuscitation/oxygen
___ Jaundice
___ Poor sleeper
___ Colic
___ Immunizations in hospital
If yes, specify vaccine:
___ Distorted skull
___ Difficulty latching/sucking
___ Formula fed
___ Breast fed (___ breast or ___ bottle)

Weight at birth: __________

Length at birth: __________

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

___ Illness accompanied by a high fever
___ Headaches (occasional or frequent)
___ Seizures/Convulsions
___ Ear infections/earaches
___ Head injury
___ Serious fall(s) or repetitive falls
___ Epilepsy
___ Meningitis
___ Allergies to foods
___ Environmental allergies
___ Chemical insensitivities
___ Neck or back problems
___ Rheumatic Fever
___ Adverse reaction to any vaccinations (even if mild)
If yes, please explain:
____
____
____

___ Dizziness
___ Diabetes
___ Hypoglycemia (low blood sugar)
___ Trouble with bladder control
___ Fainting
___ High blood pressure
___ Heart Disease
___ Asthma
___ Sinus problems
___ Constipation
___ Digestive disorders
___ Joint or muscle problems
___ Undergone any surgeries
If yes, please explain:
____
____
____
____

Developmental History
Does your child have any of the following:

___ Difficulty with crawling (on all fours)
___ Difficulty learning to ride a bike
___ Difficulty learning to read
___ Difficulty using utensils
___ Difficulty tying shoes
___ Poor hand-eye coordination
___ Did not crawl on all fours
___ Appears clumsy
___ Difficulty with writing
___ Difficulty buttoning clothing
___ Difficulty or awkward with walking/running
___ Difficulty sitting still or paying attention

How long did your child crawl (in months): __________________
At what age did your child start to walk unassisted: ____________

Comments:____
____
____

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Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

___ Hearing loss or impairment
___ Neurological disorders
___ Obsessive Compulsive Disorder (OCD)
___ ADD/ADHD
___ Dyslexia
___ Visual impairment
___ Anxiety/Depression
___ Autism/Autism Spectrum Disorder
___ Tourette's Syndrome
___ Other____________________________

Current/Past Medications and Treatment

List any medications that your child is taking or has taken in the past:
List names, dosage, frequency
____
____

List any special needs your child has:
____
____
____

List any supplements your child takes:
____
____
____

List any treatment that your child is currently undergoing with any health professional:
____
____

List any special services that your child is currently receiving at school or privately:
____
____
____

List any previous chiropractic treatment:
____
____
____

Comments: ____
____
____

Authorization for Care of a Minor

I hereby authorize Dr.___________________________D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as soon as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

Patient Health Information

The patient understands and agrees to allow Great Lakes Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

____ ____________________
Signature and relation of person completing this form **Date**

____ ____________________
Signature of a witness **Date**

Dr. Phillip J. Detlefsen
Chiropractor

Dr. Kimberly Martin
Chiropractor

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Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care is the care necessary to get rid of your symptoms or pain, while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

Insurance Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for the examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this Office. The patient also agrees he/she is responsible for all bills incurred in this Office.

Patient Signature ____ Date________________________

Consent to Treat a Minor ____ Date________________________

Guardian or Spouse's
Signature of Authorizing Care ______________________________________ Date________________________

Guardian's Social Security Number (required to treat a minor) ____

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TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's natural ability toward self healing. Our only method is specific adjusting to correct vertebral subluxations.

I ____________________________, have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on the basis

__________________________________ __________________________
(Signature) (Date)

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Standard Consent Form

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

pain	burns	swelling	sensory changes
soft tissue injury	bruising	bleeding	stroke(CVA)
discoloration	fracture	dizziness	inflammation
disc injury	nausea	weakness	soreness

By signing this I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

PATIENT SIGNATURE: ______________________________ DATE: _______________

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RECORDS RELEASE

I authorize the release of my records/x-rays or copies of such to the office of GREAT LAKES CHIROPRACTIC, 12000 Elm Creek Blvd. Suite L70, Maple Grove, MN 55369.

This records release is valid for one year from the date of my signature.

PRINTED NAME OF PATIENT: ____

NAME OF PARENT OR GUARDIAN: _______________________________________

PATIENT SIGNATURE: ___________________________ DATE: _________________

PATIENT SS#: ________________________ PATIENT DATE OF BIRTH: __________