# Tiger Family Chiropractic & Wellness Center

*Feel like yourself again.*

## Pediatric Case History *PLEASE PRINT CLEARLY*

DATE _____

CHILD'S NAME _____ BIRTH DATE _____/_____/_____ GENDER ☐ Male ☐ Female

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, and 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 occured 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.

### PERSONAL INFORMATION

PARENT'S FIRST NAME _____ MIDDLE _____

LAST NAME _____

PARENT'S FIRST NAME _____ MIDDLE _____

LAST NAME _____

CHILD'S APPROX. HEIGHT _____ WEIGHT _____

PARENT'S MARITAL STATUS

☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other

SPOUSE'S NAME _____

NUMBER OF CHILDREN & AGES _____

EMERGENCY CONTACT _____

RELATIONSHIP _____

PHONE (_____) _____-_____

### CONTACT INFORMATION

EMAIL _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

HOME PHONE (_____) _____-_____

CELL PHONE (_____) _____-_____

CELL PROVIDER _____

WORK PHONE (_____) _____-_____

ADDRESS _____

_____

CITY _____ STATE _____

ZIP _____

## Primary Complaint Information

**What is the purpose of your child's visit?** ☐ Chronic Discomfort ☐ Consultation ☐ Injury ☐ New Condition ☐ Second Opinion

**When did this condition begin?** _____

**How long has your child had this condition?** ☐ 5 days or less ☐ More than 5 days but less than 30 days ☐ More than 30 days

*(continued on next page)*

PATIENT NAME _____ DATE _____

1. **Do you have any concerns for your child's health?** _____

_____

_____

2. **Has your child been checked by a Doctor of Chiropractic?**

☐ Yes ☐ No If yes, who? _____

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

*Place of birth* ☐ Home ☐ Birth Center ☐ Hospital

*Type of birth* ☐ Midwife ☐ OB-GYN ☐ Other _____

*Was labor induced?* ☐ Yes ☐ No If yes, why? _____

*What position did you deliver in?* ☐ Squatting ☐ On Back ☐ Other _____

*Birth Trauma* ☐ Doctor assisted ☐ Twisting ☐ Pulling ☐ Vacuum Extraction ☐ Forceps

*Newborn Trauma (medical procedures and tests)* _____

_____

4. **Were you able to breastfeed your child?** ☐ Yes ☐ No How long? _____

5. **According to the National Safety Council approx 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured on playgrounds annually. Can you recall any such jolts, falls or traumas to your child?** ☐ Yes ☐ No

*Please describe* _____

_____

6. **What type of foods make up your child's diet?** _____

_____

Does your child consume artificial sweeteners? ☐ Yes ☐ No

Does you child consume multiple servings of plain water daily? ☐ Yes ☐ No

7. **Place a check by 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 _____

8. **Has your child been treated with medications?** ☐ Yes ☐ No

If yes, which ones and what did they treat? _____

_____

Is you child currently on any medications? *(Please list)* _____

_____

Any surgeries? *(Please list)* _____

_____

PATIENT NAME _____ DATE _____

# Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, 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 HIPPA 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purposes of treatment, payment, and health care operations the chiropractic physician has the right to refuse to give care. I have and understand how my Patient Health Information will be used and I agree to these policies and procedures.

☐ **I agree with this statement of authorization.**

**SIGNATURE** _____ **DATE** _____

# Informed Consent *PLEASE PRINT CLEARLY*

PATIENT NAME _____

CLINIC NAME Tiger Family Chiropractic & Wellness Center DOCTOR chiropractors employed by Tiger Family Chiropractic & Wellness Center

ADDRESS 3700 I-70 Drive SE, Suite 110, Columbia, MO 65201

PHONE ( 573 ) 443-1414 FAX ( 573 ) 443-1416

**The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.**

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any health care procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**
  In addition to chiropractic adjustments, I intend to use the following treatments:

  _____

  _____

  These treatments involve the following additional significant risks:

  _____

  _____

*(Continued on next page)*

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest.
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction.
  - Surgery.

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.** I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the doctor any questions, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended.

HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO THAT TREATMENT.

PRINTED NAME _____ DATE _____

SIGNATURE _____ SIGNATURE OF PARENT OR GUARDIAN (IF A MINOR) _____

**WITNESSES**

PRINTED NAME _____ SIGNATURE _____