THE SOURCE
CHIROPRACTIC

PEDIATRIC PATIENT INTAKE

Date: _____ Child's Name: _____ Birth Date: ___ /___ /___ Age: _____
Parent Name: _____ Parent Name: _____
First *Last* *First* *Last*
Address: _____ City: _____ State: _____ Zip:_____
Home Phone: _____ Parent Work Phone: _____
Sex: Male | Female Number of Siblings: _____ Current Weight: _____ Current Height: _____

Pregnancy & Fertility History

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

Please explain any notable episodes of mental or physical stress during your pregnancy:
_____
_____
Please explain any other concerns or notable remarks about your child's conception or pregnancy:
_____
_____

Labor & Delivery History

Child's birth was: Vaginal Birth Scheduled C-section Emergency C-section
At how many weeks was your child born? _____

Child's birth was: At home At a birthing center At a hospital Other: _____
Obstetrician/Midwife's Name: _____

Please circle any applicable interventions or complications:

Medical Induction	Breech Induction	Pain meds	Epidural	Epidural
Pitocin	Episiotomy	Vacuum extraction	Forceps	Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery:
_____
_____

For Children Under 3

Child's birth weight: _____lbs. oz. Child's birth height: _____ in.
APGAR score at birth: _____ APGAR score after 5 minutes: _____

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Growth & Development History

Is/was your child breastfed? Yes No If yes, how long?
Difficulty with breastfeeding? Yes No
Did they ever use formula? Yes No If yes, at what age? If yes, what type?

Did/does your child ever 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:

At what age did the child:
Respond to sound: ____ Follow an object: ____ Hold their head up: ____ Vocalize: ____
Teethe: ____ Sit alone: ____ Crawl: ____ Walk: ____ Begin cow's milk: ____ Begin solid foods: ____

Does your Child seem to be developing typically for their age? _____

Please list any food intolerance or allergies, and when they began: _____
_____

Please list your child's hospitalization and surgical history, including the year: _____
_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in their lifetime, including the year: _____
_____

Have you chosen to vaccinate your child? No Yes, on an alternate schedule Yes, on schedule
If yes, please list any vaccination reactions: _____

Has your child received any antibiotics? Yes No
If yes, how many times and list reason: _____

Night terrors or difficulty sleeping? Yes No
If yes, please explain: _____

Behavioral, social or emotional issues? Yes No
If yes, please explain: _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet:
Mostly whole, organic foods Pretty average High amount of processed foods

Health Concerns:
Please list any health concerns below:
_____
_____

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When did the condition first begin? _____

How did the problem start? Suddenly Gradually Post-Injury

Has your child ever received care for this condition before? Yes No
If yes, please explain: _____

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better? _____

What makes the problem worse? _____

Health Goals:
What are your top three health goals for your child?
1. _____
2. _____
3. _____

CIRCLE ANY AND ALL OF THESE PROBLEMS WHICH HAVE HAPPENED

dizziness/ vertigo	asthma	kidney problems	chronic fatigue
headaches/migraines	trouble eating	bladder problems	rashes
antibiotics	allergies	bed wetting	trouble sleeping
ear infections	arm numbness	sciatica	add / adhd
grating of neck	arm pain	leg numbness	gerd
difficult breast feeding	night terrors	feet numbness	anxiety
neck pain/ stiffness	shoulder pain	low back pain	nervousness
torticollis	heart disorders	hip pain	epilepsy
autism spectrum	colic	mid back pain	leg pains
chronic sinus	stomach disorders	knee pain	vaccine reaction
throat issues	nausea	liver disease	bowel problems
sensory processing issues	tongue/lip tie	reflux	other

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Authorization for Care of Minor

I hereby authorize The Source Chiropractic and doctor(s) to administer care, as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Print: _____ Signed: _____ Date: _____

***IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT & SIGN* WRITTEN CONSENT FOR A CHILD/MINOR**

NAME OF PATIENT WHO IS A CHILD / MINOR:

_____

I AUTHORIZE THE SOURCE CHIROPRACTIC DOCTORS TO PERFORM A FUNCTIONAL EXAM, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY CHILD/MINOR.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY CHILD/MINOR. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY THE SOURCE CHIROPRACTIC.

_____ _____ _____

Guardian Name *Guardian Signature* *Date*

_____ _____

Guardian Relationship to Child/Minor *Witness Signature (Office Staff)*

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, and dizziness. Some of these symptoms are similar presentations to people experiencing a stroke; if you have a history of strokes or think you may be experiencing one, please let us know immediately.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to Evaluate and Adjust a Minor Child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____	_____	_____
Print Name	Signature	Date

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The Source Chiropractic No Call, No Show Cancellation Policy

Here at The Source Chiropractic, we understand that life can throw us unexpected emergencies. These unanticipated things are not always within our control. Due to appointments being in high demand, we ask that you do your best to notify us in advance about any changes to your appointment. It is our commitment to you as a Source member that you have an exceptional experience here at our office. Out of respect for our chiropractors and other Source members, we appreciate at least 24 hours advance notice from our practice members when they are unable to keep their scheduled appointment. This is valuable time that can be dedicated to someone who may have an immediate need for care.

I understand:

• If I have not shown up within 15 minutes past my scheduled appointment and have not notified the office, it will be considered a No Call, No Show Cancellation. In this case, I will be charged 50% of my appointment cost.

• My care plan payments do not cover payment for missed appointments; therefore, I am responsible for these additional charges when applicable.

• Optional reminder texts, emails, and/or calls can be made 24 hours prior to my appointment, as a courtesy, and that I am expected to be in attendance of my appointment.

I authorize The Source Chiropractic to use the credit card I have on file for these additional charges when applicable.

To reschedule your appointment, please call 520-344-9651. If you are unable to reach us, please leave a detailed message on our voicemail system available 24 hours a day, 7 days a week. You may also cancel via email: sourcechirotucson@gmail.com.

Thank you for your understanding. We are available to answer any questions you may have. We look forward to caring for you here at The Source Chiropractic!

I have read and agree to the terms of The Source Chiropractic's No Call, No Show Cancellation policy.

_____	_____	_____
Print Name	Signature	Date

Office Staff: _____