**Pediatric/Youth Health Profile (Ages 12 and under)**

\*Please do your best to fill out *everything* on this intake form. It is important that I understand past and current stressors that may have affected or could affect your child’s health. It is important for me to know the following information, even if it may not seem relevant to the reason for which you are coming in for care. Please know that I value your time and aim to provide you the best care possible. Thank you for choosing Hands on Wellness!

**Check type of care desired:** \_\_Temporary Relief / \_\_Stabilization / \_\_Family Health/ Prevention/ \_\_Doctor’s Advice

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_

Siblings’ Names and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Concerns**

**What is the reason for your appointment?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did this situation or concern first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this related to an \_\_\_ auto accident \_\_\_ injury** Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you done anything for or gotten any advice or treatment for this issue outside of this office? Yes No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities **aggravate** their condition/pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities **alleviate** their condition/pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Chiropractic History**

Has your child ever been adjusted? Y N Doctor or Office’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technique used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Adjustment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

**Mom’s Pregnancy:***check all that apply*  If adopted and no details are known please check here \_\_\_\_\_

Chemical: \_\_\_Tobacco \_\_\_Alcohol \_\_\_Medications \_\_\_ Recreational drugs \_\_\_Special Diet

Physical/ Emotional: \_\_\_Falls/injuries \_\_\_Abuse (Physical, sexual, or emotional) \_\_\_Complications

*Details of any checked*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Birth:***check all that apply*

Third Trimester Presentation: \_\_\_\_\_ Vertex \_\_\_\_\_ Breech \_\_\_\_\_ Transverse \_\_\_\_\_ Face/Brow

Type of Birth: \_\_\_\_\_Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Suction or Vacuum \_\_\_\_\_ Cesarean (ER or planned?)

Interventions: \_\_\_\_\_ Pitocin \_\_\_\_\_ Epidural \_\_\_\_\_ Ruptured Membranes \_\_\_\_\_ Episiotomy

Delivery Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OB/Midwife: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Developmental History:**

**Breast Fed**: Yes No How Long? \_\_\_\_\_\_\_\_\_\_ **Formula Fed:** \_\_\_\_\_Dairy \_\_\_\_\_ Soy How Long? \_\_\_\_\_\_\_

Breastfeeding issues / Reason formula fed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age when **solids** were introduced \_\_\_\_\_\_\_\_\_\_\_ Texture sensitivities? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food Sensitivities** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicines \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physical, emotional, or sexual abuse?** Yes No **Nightmares or Night Terrors?** Yes No

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Crawled before walking?**  Yes No N/A **Shoulder or elbow dislocations?** Yes No

Played in a **hanging/bouncy swing** (Johnny Jump-Up)? Yes No Plays on a **trampoline**? Yes No

**Can s/he currently**: (mark all that apply) \_\_\_Sit Independently \_\_\_Crawl forward with opposite hand and knee \_\_\_ Stand Independently \_\_\_Walk Independently \_\_\_ Jump \_\_\_ Skip \_\_\_ Pinch \_\_\_Read \_\_\_ Write

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mark all that apply for current **bowel/bladder** trends: \_\_\_ diapers all day and night \_\_\_ diaper/ pull-up at night only

\_\_\_ teaching Elimination Communication \_\_\_ enuresis (bed-wetting) \_\_\_ bowel movement at least once daily

**Females**: Menarche (1st menstrual cycle) Yes No If yes, Age: \_\_\_\_\_\_ Cramps/PMS? Yes No

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health History**

**Mark each they have had in the past or have now. Put “P” for past and “N” for now.**

\_\_\_ Ear Infections/Aches \_\_\_ Colds/Flu \_\_\_ Headaches \_\_\_ Poor Appetite

\_\_\_ Sinus/Allergies \_\_\_ Asthma \_\_\_ Eczema/Skin Condition \_\_\_ Colic

\_\_\_ Digestive problems \_\_\_ Changes in bowel/bladder \_\_\_ Reflux/Gassy \_\_\_ Stomach Aches

\_\_\_ Concussion/Head injury \_\_\_ Neck or Back pain \_\_\_ Heart/Valve Issues \_\_\_ Seizures

\_\_\_ Motor Integration Issues \_\_\_ Sensory Integration Issues \_\_\_ Learning Disabilities \_\_\_ADD/ADHD

\_\_\_ Diabetes \_\_\_ Anemia \_\_\_ Bed Wetting \_\_\_ Hernia

\_\_\_ Muscle pain \_\_\_ Growing pains \_\_\_ Arm problems \_\_\_ Leg problems

\_\_\_ Poor posture \_\_\_ Scoliosis \_\_\_Walking trouble \_\_\_ Broken bones

\_\_\_ Surgery \_\_\_ Sports Injury \_\_\_ Auto Accident \_\_\_ Scarlet Fever

\_\_\_ Chicken Pox \_\_\_ Rubella \_\_\_ Measles \_\_\_ Rotavirus

\_\_\_ Mumps \_\_\_ Rubeola \_\_\_ RSV \_\_\_ Diptheria

\_\_\_ Fifth Disease/ Parovirus \_\_\_ Pertussis/Whooping Cough \_\_\_ Hand, foot, mouth \_\_\_ Croup

\_\_\_ Other/ Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Providers** (Office and Doctor/provider name, last visit date and reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Vaccine History**: \_\_\_Full CDC schedule \_\_\_ Selective schedule \_\_\_ Delayed, Full schedule \_\_\_ None

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications** (type and reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Supplement** (type and reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child’s Diet / Mom’s Diet if Breastfeeding**

Daily/High Weekly/Moderate Monthly or less/Low None/Never

Dairy (milk, yogurt, cheese) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Meat \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Vegetables \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Fruit \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Gluten (flour, wheat, pasta) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Soy \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Sugar \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Soda/Energy Drinks \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Fast food \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Water \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Circle all that apply if mom is breastfeeding: caffeine, coffee, tea, alcohol, tobacco, medications of any type

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Household Habits**

Do you **filter** your drinking/cooking/shower water? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat **organic foods**? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use **organic health products** (soaps, shampoos, detergents)? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you **filter your air** at home? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Chiropractor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Consent Form**

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

***Chiropractic*** is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

***Health*** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

***Subluxation*** is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body’s overall healthy performance.

Subluxations are corrected and/or reduced by an ***adjustment***. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

**Consent to evaluate 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature Date

**HEALTHCARE AUTHORIZATION FORM**

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Hands on Wellness to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS:

\_\_\_\_\_\_ I give permission to Hands on Wellness to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

\_\_\_\_\_\_ If Hands on Wellness contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

\_\_\_\_\_\_ I give permission to Hands on Wellness to use my name on a welcome board, referral board, and birthday board.

\_\_\_\_\_ I give permission to Hands on Wellness to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

\_\_\_\_\_ I give permission to Hands on Wellness to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

\_\_\_\_\_\_ I give Hands on Wellness permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Hands on Wellness permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Hands on Wellness plus 7 years or until revoked by me.

**RIGHT TO REVOKE AUTHORIZATION:**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Hands on Wellness. The written notice must contain the following information:

Your name and date of birth;

A clear statement of your intent to revoke this AUTHORIZATION;

The date of your request; and

Your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Hands on Wellness for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Hands on Wellness will not refuse to provide treatment however, it will not be possible for Hands on Wellness to contact me to schedule appointments or discuss my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

**HEALTHCARE AUTHORIZATION**

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Personal Representative (if someone is designated to act on your behalf/or for minor)

Parent or Personal Representative’s name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_