# KEY TO LIFE CHIROPRACTIC

## CHILDREN'S CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire fully and remember to bring it with you for your first appointment. Your answers will help us determine how chiropractic care can help your child.

**PERSONAL INFORMATION:**

Child's Last Name: _____ First Name: _____ Sex M___F___

DOB: _____ Weight: _____ Length: _____ APGAR: _____

Previous Chiropractic Care? _____ If so, when and why: _____

_____

Parent's Names: _____ & _____

Phone Number: _____ Address: _____

_____

*The primary system in the body which coordinates health is the nervous system. From the birth process until the present, events have occurred 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. This interference is called the Vertebral Subluxation Complex.*

***The following form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of Your child's nervous system and therefore impair your child's inborn health and well-being.***

**PRENATAL HISTORY:**

**Why are you bringing your child in for Chiropractic care?** _____

_____

**Who is your regular pediatrician?** Physician and Facility Name: _____

Address: _____

**Birth related questions for children under 10 years old:**

**Did you have ultrasounds during the pregnancy?** Yes or No Frequency: _____

**Place of birth:** -Home -Birthing Center -Hospital **Provider:** -Midwife -OB-GYN other: _____

**Type of birth:** -Vaginal or C-Section **Was anesthesia used?** Yes or No -Spinal -Epidural -Other _____

**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) _____

**Did you breast-feed your child?** Yes or No How long? _____

*Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological, and digestive systems.*

*According to the National Safety Council, approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals about a quarter of a million children are injured on playgrounds annually.*

**Can you recall any such jolts, falls or traumas to your child?** Yes or No Please Describe: _____

_____

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Child's Name_____

**Any fractures or dislocations** (what, when, how, etc.)? _____

_____

**Which sports does your child play?** -Soccer -Football -Gymnastic -Karate -Hockey -Lacrosse -Basketball -Dance -Wrestling -Baseball -Other _____

**Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting?** Yes or No **Is it in front of a** -computer -TV -tablet -game console

**How would you rate your child's diet?** -Poor -Fair -Good -Excellent

**Does your child consume artificial sweeteners?** Yes or No **Fluoridated water?** Yes or No

**Circle any of the following conditions your child has suffered from:**

-Colic -Irregular sleeping patterns -Night terrors -Tantrums -Ear Infections -Asthma
-Poor Digestion -Bloated Abdomen -Constipation/Pain -Other Bowel Complaints
-Red Rings around Anal Are -Itchy Genital Area -Thickly Coated or Patchy White Tongue
-Eczema -A Chronic Hair or Foot Odor -Bed Wetting -Muscle Aches or Weakness
-Repeated Infections or Colds -Headaches -Seizures -"Spacey" or "Zoned Out" look in eyes
-ADD or ADHD -Learning Disorders -Emotional Disorders
-Unexplained Aches or Pains If so, where? _____
-Other Medical Diagnoses or anything else you are concerned about _____

**Please list all Allergies:** _____

**How often has your child been treated with drugs/antibiotics?** _____

What drug(s), for what, and when? _____

_____

**Were you informed of their adverse reactions?** Yes or No

**If it was an antibiotic, was your child recommended to take a probiotic?** Yes or No

**Any Surgeries?** Yes or No If so, for what and when? _____

_____

*The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered.*

**Were you adequately informed of the risks of vaccinating your child?** Yes or No

**Did your child experience any neurological, developmental, behavioral, emotional, or physical changes within 3 months after any shots?** Yes or No If yes please describe _____

_____

**Was it reported by you or your doctor?** Yes or No

**Was it reported to the Vaccine Adverse Event Reporting System (VAERS)?** Yes or No

## KEY TO LIFE CHIROPRACTIC

*Today, we are becoming more aware of how current technological life styles and practices exposes our children's nervous systems to continuous stresses.*
*These result in Vertebral Subluxations.*

*Current scientific research is showing the direct relationship between the function of the nervous system and immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.*

*Your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.*

# AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Wayne Christianson and any licensed chiropractors affiliated within KEY TO LIFE CHIROPRACTIC for services, to administer care as deemed necessary to my son/daughter.

Child's Name: _____ Birth Date: _____

Relationship to Child: _____

Parent/Guardian Name: _____
Parent/Guardian Signature: _____ Date: _____

Witness Name: (Office Staff Only) _____
Witness Signature: _____ Date: _____

# Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.**

| Print Patient Name | Parent Signature | Date |
|---|---|---|

WITNESS:

| Printed Name | Signature | Date |
|---|---|---|