Schuyler Creek
CHIROPRACTIC CENTER

New Child Health History

Child's Last Name: _____ Child's First Name: _____ Middle Initial:_____

Birthdate: _____ Age:_____ Sex: Male Female

Address: _____ City:_____ State:_____ Zip Code:_____

Telephone Number: _____ Email Address:_____

Parent #1 Name: _____ Parent #1 Birthdate: _____

Parent #1 Contact Number: _____ Email Address:_____

Parent #2 Name: _____ Parent #2 Birthdate: _____

Parent #2 Contact Number: _____ Email Address:_____

Current Weight: _____ Current Height: _____ Date of Last Growth Spurt: _____

Purpose of This Appointment: _____

_____

BIRTH/CHILDHOOD HISTORY

Type of Birth: Normal Vaginal: _____ Forceps: _____ Cesarean:_____ Suction Cap/Vacuum:_____

Location: Home: _____ Birthing Center:_____ Hospital:_____

Problems During Pregnancy: _____

Problems During Labor: _____

Congenital Abnormalities/Defects: _____ If Yes, Please Explain: _____

_____

Vaccination History: _____None _____ Up to Date _____ Delayed Other: _____

Any reactions you were aware of? _____

_____

What is your child's diet like? _____

_____

Any known allergies? _____

_____

Number Of Hours Sleeping Per Night:_____ Quality Of Sleep: Good:_____ Fair:_____ Poor:_____

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New Child Health History

Pediatrician/Family MD: _____

Date Of Last Visit: _____ Purpose:_____

Number of Doses Of Antibiotics Your Child Has Taken: In The Past Six Months: _____ Lifetime:_____

Previous Chiropractor:_____

Date Of Last Visit:_____ Purpose:_____

Has Your Child Ever Been Treated On An Emergency Basis: _____ If Yes, Please Explain: _____

_____

_____

Has This Child Ever Suffered From:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Growing Pains
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ Allergies to_____
- ☐ Allergies to _____
- ☐ Allergies to_____
- ☐ Other_____

Has This Child Ever Suffered The Following Spinal Traumas?

- ☐ Fall In Baby Walker
- ☐ Fall From Crib
- ☐ Fall From Highchair
- ☐ Fall From Changing Table
- ☐ Fall From Bed or Couch
- ☐ Fall Off Swing
- ☐ Fall Off Slide
- ☐ Fall Off Monkey Bars
- ☐ Fall Off Skateboard Or Skates
- ☐ Fall Off Bicycle
- ☐ Fall Down Stairs
- ☐ Other _____
- ☐ Other_____

Has This Child Ever Sustained An Injury Playing Organized Sports? _____ If yes, Please Explain:_____

_____

Has This Child Ever Sustained Injuries In An Auto Accident? _____ If Yes, Please Explain: _____

_____

781 Hudson Avenue
Stillwater NY 12170

Dr. Kelli Patenaude, CACCP
Dr. Brady Patenaude

518-664-4525
Schuylercreekchiro.com

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New Child Health History

Present History: _____

_____

_____

Surgeries: _____

Medications: _____

Accidents: _____

Family History: _____

_____

Authorizations For Care Of Minor

I Hereby Authorize This Office and Its Doctor(s) To Administer Care As They So Deem Necessary To My Son/Daughter/Ward (Upon Approval of Parent or Guardian).

Signed: _____ Relationship to Patient: _____ Date: _____/_____/_____

I Realize That I Am Responsible For All Fees Charged By This Office And I Agree To Pay For All Services Provided. X-Rays Remain The Property Of This Office.

Signed: _____ Date: _____/_____/_____

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INFORMED CONSENT FOR TREATMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not mutually acceptable, the doctors will refer you to another provider who we feel can further assist you.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you feel experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a previous disc injury, or cause minor joint, ligament, tendon, muscle, or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

If you have any questions concerning the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

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Patient Acknowledgement of Receipt of SCCC's Notice of Privacy Practices

By signing below, I acknowledge receiving a copy of SCCC's Notice of Privacy Practices, dated 09/23/2013.

_____ _____
Patient's Name Date of Birth

_____ _____
Signature of Patient or Personal Representative* Date

*If signed by a Personal Representative, the following information must also be included:

_____
Name of Personal Representative

_____
Description of the Personal Representative's Authority to Act on Patient's Behalf

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