

VITALITY CHIROPRACTIC FAMILY WELLNESS CARE

4080 Loma Vista Rd, Ste. H, Ventura, CA, 93003 • (805) 648-6866 • VITALITYCHIROPRACTIC@GMAIL.COM

Sharon MacDonald BA, DC, FICPA

Children's Health History Form

Today's Date _____

Welcome! Thank you for choosing chiropractic and for trusting our office to address the health and wellness needs of your child. Please take the time to answer the following questions completely. Your answers will help us better understand the health concerns and needs of your child.

Name _____ Birth Date ____/____/____ Age _____ M / F

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Father's Name _____

Sibling(s) Name(s) _____

Home Phone () _____ Cell Phone () _____ Bus. Phone () _____

Reason for consulting our office _____

Whom may we thank for referring you? _____

Health Profile

If your child has no symptoms or complaints and is here for wellness care, please circle YES

Otherwise, please briefly describe the nature of your visit, including the area of chief complaint and the affect it has had on your child's day to day life. _____

If he/she is experiencing pain, is it... (please circle)

Sharp Dull Constant Comes and Goes Travels (where) _____

Since the problem started, is it ... About the same Getting Better Getting Worse

Does the problem interfere with... School Sleep Walking Sitting Hobbies

Does your child suffer from any of the following conditions?

ADD/ADHD Allergies Asthma Autism Bed Wetting Colic
Ear Infections Irregular Sleep Patterns Headaches Learning Disorders
Night Terrors Poor Digestion Repeated Infections / Colds Seizures Tantrums
Other _____

What medications if any, is your child taking? (Include any vitamins or supplements) _____

Other Doctors seen for this problem Chiropractor Pediatrician Other _____

Doctor / Therapist's Name _____ Phone() _____

On a daily basis we experience physical, chemical, and emotional stressors that can accumulate and result in a serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering

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the following questions will give us a profile of the specific stresses your child has faced in their lifetime, allowing us to better assess the challenges to your child's health potential.

Pregnancy, Birth and Delivery

Was the mother under regular chiropractic during this child's pregnancy? Yes No
Were there any complications during this child's pregnancy? Yes No
Explain _____
Place of birth: Home Birthing Center Hospital
Provider: Midwife OB-Gyn Other _____
Type of Birth: Vaginal C-Section Was anesthesia used? _____ Type _____
Was labor induced? _____ If yes, why? _____
What position did you deliver in: Squatting On Back
How long was the labor? _____ How long was the delivery? _____
Birth Trauma: Twisting / Pulling Vacuum Extractor Forceps
Presentation at birth: Vertex Brow
Newborn Trauma (Medical procedures and/or tests) _____

Infancy and Childhood Years

Was your child breast-fed? Yes No How long? _____
Was your child vaccinated? Yes No Selectively (Which vaccinations) _____
Did your child experience any behavioral, emotional, or physical changes or setbacks within 3 months after receiving any shots? Yes No Was this reported to your medical doctor? Yes No
Did / does your child have any childhood illnesses? Yes No Explain _____
Has there been any prolonged use of medications such as antibiotics or inhalers? Yes No
If yes, what for? _____
Has your child suffered any serious falls (from height over 3 feet such as a change table, bed, couch) Yes No
Explain _____
Has your child suffered had any sports injuries or car accidents? Yes No
Explain _____
Has your child had any broken bones, hospitalizations, and/or surgeries? Yes No
Explain _____
Has the child suffered any other traumas (physical or emotional) Yes No
Explain _____

Lifestyle

What sports/activities does your child participate in Baseball Basketball Dance Football
Gymnastics Hockey Karate Lacrosse Skiing Surfing Swimming
Wrestling Other _____
In addition to sitting in the classroom, does your child spend additional / prolonged time sitting? Yes No
Is it in front of a computer? _____ TV? _____
How would you rate your child's diet? Poor Average Good
Does she/he consume soda, caffeinated beverages, or artificial sweeteners? Yes No
How Much? Soda _____/day Caffeine _____/day Sugar _____/day Artificial Sweeteners _____/day

Please give us any other health information you feel would be helpful _____

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Informed Consent and Authorization for Chiropractic Care

I have reviewed the above Health Profile and have completed it accurately and to the best of my knowledge. I understand that this information will be used to assess my condition (or the patient named below for whom I am legally responsible) and determine the most appropriate course of care. If there is any change in my condition or my medical status generally, I will inform the doctor so that she may alter my care plan as needed.

I (or the patient named below for whom I am legally responsible) request and consent to undergo care as recommended by the doctor including the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapy, exercise prescription and diagnostic x-rays, by the doctor of chiropractic named above and / or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for, the doctor of chiropractic above, including those working at the clinic or office listed or any other office of clinic.

I have been advised of the associated risks / benefits of undergoing care as well as other treatment options which I may pursue exclusively or in conjunction with my care in this office. I understand and am informed that as in the practice of other health professions, in the practice of chiropractic there are some risks to treatment, including but not limited to, strain, sprain, fractures, disc injuries, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment, based on the facts known, during the course of the treatment.

I understand that the information provided herein is strictly confidential and that my written authorization will be required in order for any of my information to be released.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the enter course of treatment for my present condition and for any future conditions for which I seek treatment in this office.

To Be Completed By Patient:

Print Patient's Name

Patient Signature

Date

To Be Completed By Patient's Representative or If Minor, By Parent or Guardian

Print Name of Patient

Print Name of Patient's Parent / Guardian or Representative

Signature of Patient's Parent / Guardian or Representative

Relationship to / or Authority of Patient's Representative

Date

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Office Policy

We have an open communication policy in this office. To avoid any misunderstandings between the patient and the office, we appreciate you taking a moment to review the following information. We welcome any questions you may have regarding this information or your care in general.

Cash Patients

It is customary that you pay for each visit as you go. X-rays must be paid for on the day that they are taken. For those cash patients who would like to establish a prepaid plan, please ask for more information. For those cash patients who are unable to pay according to the schedule already mentioned we will gladly set up a payment plan for you.

Insurance Patients

Please have your insurance card ready and a form of picture identification so we can make a copy of it for your file. Once we have confirmed that your health insurance covers chiropractic care, we will be happy to bill your insurance company. Most of the insurance companies pay between 60 to 80%. The remainder then becomes your responsibility and will be billed to you directly. Remember, you the patient, are ultimately responsible for the bill. We will be happy to help you with any insurance problems or questions that may arise.

All Patients

Every appointment represents a specific amount of time reserved for you and your family. Should you fail to keep your appointment without properly notifying our office 24 hours in advance, a minimum fee of \$50.00 will be posted to your account.

Your care is of the utmost importance to us. If you have a financial problem, please let us know ahead of time. We will work with you to arrange a payment plan that is both manageable and agreeable to you.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named office policies

Print Patient's Name

Print Name of Patient's Parent / Guardian or Representative

Patient Signature

Signature of Patient's Parent / Guardian or Representative

Date

Relationship to Patient