

Date _____

LaBelle Chiropractic
1152-B Haywood Road
Greenville, SC 29615

Pediatric Case History for Chiropractic Care

(Please Print Clearly)

Last Name		First Name		Middle I.
Home Address			Social Security Number	Sex M F
Home Phone ()	Work Phone ()	Cell Phone ()	Date of Birth __/__/____	Age
Occupation	Employer	Email Address		Marital Status M S D W
Spouse's Name (or parent)		Number of Children	How did you hear about our office?	

CONSENT TO TREAT A MINOR

Being the parent or legal guardian of this child, I hereby authorize this office, doctors, and staff to examine and administer care to my son/daughter as the doctor deems necessary.

Printed Name

Signature

Parent Legal Guardian

LOSS OF WHOLE BODY HEALTH (Birth to Present)

Most health problems are present for years, many times undetected, before we are aware of them. Eventually your child begins to experience symptoms and random bouts of sickness. Please complete the following questions as closely and carefully as possible. Please check the appropriate answers:

Prenatal History

- Born by forceps
 - Born by cesarean
 - Born breech
- Surgeries:* Ear Tubes Tonsillectomy Other: _____
- Vaccinations:* _____

Childhood History

- On antibiotics
 - Uses inhalers
 - Eats unhealthy foods
 - Little to no exercise
 - School stress
 - Home stress
 - Physical stress
 - Computer (home or school)
 - Sits mostly
 - Stands mostly
 - Stomach sleeper
- Antibiotics/Uses:* _____
- #of Medications/day:* _____
- What are medications taken for?*
- 1) _____ 2) _____
- 3) _____ 4) _____
- Sports/Hobbies:* Football Basketball Baseball Volleyball
 Soccer Gymnastics Cheerleading Other: _____
- Car Accidents:* Yes No *When:* _____
- Briefly describe:* _____
- Falls/Injuries:* _____ *When:* _____

How would you rate your child's immunity? (0 = extremely low, 10 = extremely high)

0 1 2 3 4 5 6 7 8 9 10

Many times symptoms indicate a long standing spinal condition. Please check off any symptoms your child has now or has experienced in the past.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Temper Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Concentration	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain
<input type="checkbox"/>	<input type="checkbox"/>	Arm/hand pain or numbness	<input type="checkbox"/>	<input type="checkbox"/>	Leg/foot pain or numbness
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stroke

Please describe your child's symptoms or reasons for making this appointment:

How long has your child had this condition? _____

Has your child had a similar condition in the past? _____

What makes it worse? _____

What relieves it? _____

Do you feel your child's symptoms have been getting: better same worse?

Is the pain: sharp dull burning tight throbbing numb?

Is this condition interfering with: school home routine family?

What doctors has your child seen about this condition? _____

Has your child seen a Chiropractor before? yes no Who? _____

When? _____ Approximately how many visits? _____

Do you feel like your child benefited from chiropractic care? _____

Present Primary Physician: _____

AUTHORIZATION TO ADMINISTER CARE

INIT____ I authorize Dr. LaBelle, and whomever he may designate as his assistant, to administer treatment as is necessary. I also certify that no guarantee has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INIT____ I authorize the release of any medical information necessary to process my insurance claim and I also certify that all information given to this office is correct and complete.

X-RAY NOTE

INIT____ The amount paid LaBelle Chiropractic Center for x-rays is for examination only. The x-ray negatives will remain property of this office, where they may be seen at any time as required by federal law.

FINANCIAL RESPONSIBILITY

INIT____ I agree to be personally responsible for all charges I incur in this office. It is the policy of this office that all visits be paid in full at the time services are rendered unless other arrangements have been made.

Please choose the option that is best suited to your needs: Insurance Medicare Cash (no insurance)

I have read the information stated above and have answered everything to the best of my knowledge.

Signature: _____ Date: _____

Terms of Acceptance

Patient Name: _____

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and to heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and his only means is the correction of the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also, No statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effects. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice insurance costs less than his car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will do his utmost to care for you in the safest and most effective manner, just as he would his own family.

I have read the above, understand it fully and undertake chiropractic care on this basis.

Signature

Date

HIPAA - Health Insurance Portability & Accountability Act

The following is an explanation of our Privacy Policies for this office.

- Our office does NOT distribute or make available to any outside source your private personal health information.
- Your information is secure and is used only in submitting claims to third party carriers for payment of services.
- Our office is set up as an open adjusting environment.
- Our office may send you seasonal cards or birthday cards.
- Our office may call you to confirm or reschedule an appointment if necessary.
- A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our policies is available for you to read and take a copy with you. Please ask the front desk for it.

By signing, I have read, understand and agree to the privacy policies for this office. I can take a copy for my records. I understand that if I choose not to participate that I can and will notify the LaBelle Chiropractic Center staff of my concerns in writing.

Signature

Date