A+ Healthcare/
Marsden Family
Chiropractic
3304 W. Broadway Business Park Court,
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Columbia, MO 65203

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Consent to Treatment of a Minor Child

I hereby authorize Dr._____ and whomever she/he may designate as his/her assistants to administer treatment during the recommended treatment plan, as he/she deems necessary to.

Authorization is given on _____ day of _____, 20_____.

_____
Signature of Parent or Guardian

Date: _____

Witnessed: _____

Child Health History Form

A+ Healthcare · 3304 W. Broadway, Business Park Ct. Ste I, Columbia, MO 65203
(573) 445-3702 · www.a-plushealthcare.com · a.plus.chiro@gmail.com

Personal Information

Date:_____

Child's Name: _____ Patient Number: _____

Parent (s) Name: _____

Sibling's Names & Ages: _____

Child's Age: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Social Security Number: _____-____-_____ Insurance Id: _____

Address: _____

City:_____ State: _____ Postal Code:_____

Home Phone: (_____) _____- _____ Other Phone: (_____) _____- _____

Other Phone: (_____) _____- _____ Email: _____@_____

Family Doctor's Name: _____ Phone: (_____) _____- _____

Has your child received chiropractic care before? : ☐ Yes ☐ No

If yes, who is your child's previous Doctor of Chiropractic? _____

The date of last visit: : _____/_____/_____ Reason for last visit: _____

Other professionals seen for this condition: _____

Results with that treatment: _____

Recent Tests Done (Please list date):

☐ Blood Work _____/_____/_____ ☐ Urine _____/_____/_____ ☐ X-ray _____/_____/_____

Please let us know the purpose for your child's visit:

☐ Crisis Management ☐ Early Detection of Problems ☐ Prevention ☐ Wellness

☐ Maximizing normal growth and Development ☐ Other:_____

Who may we thank for referring you? _____

Present Health Concerns

Major: _____

Minor: _____

When did the problem being? _____

Is this problem: ☐ *Occasional* ☐ *Frequent* ☐ *Constant* ☐ *Intermittent*

Does the problem radiate? ☐ *Yes* ☐ *No* *If Yes, where?* _____

What makes the problem worse? _____

What makes the problem better? _____

Is the problem worse during a certain time of day? ☐ *Yes* ☐ *No*

If Yes, when? _____

Does this interfere with your child's sleep? ☐ *Yes* ☐ *No*
Eating? ☐ *Yes* ☐ *No*
Daily Routine? ☐ *Yes* ☐ *No*
Is this becoming worse? ☐ *Yes* ☐ *No*

Often seemingly unrelated symptoms can manifest as other health concerns. Please check if your child has any of the following:

☐ *headaches*	☐ *chest pressure*	☐ *weight loss*
☐ *dizziness*	☐ *breast pain*	☐ *weight gain*
☐ *irritability*	☐ *frequent colds*	☐ *dental problems*
☐ *fatigue*	☐ *sinus congestion*	☐ *fevers*
☐ *depression*	☐ *sore throats*	☐ *heart palpitations*
☐ *loss of balance*	☐ *ear pain/infections*	☐ *numbness in feet*
☐ *loss of concentration*	☐ *asthma*	☐ *numbness in hands*
☐ *fainting*	☐ *cold sweats*	☐ *weakness*
☐ *ears buzzing*	☐ *bronchitis*	☐ *heartburn*
☐ *poor coordination*	☐ *pneumonia*	☐ *muscle cramps*
☐ *vision changes*	☐ *difficulty breathing*	☐ *upper back pain*
☐ *loss of memory*	☐ *shortness of breath*	☐ *neck pain*
☐ *loss of smell*	☐ *allergies*	☐ *low back pain*
☐ *loss of taste*	☐ *constipation*	☐ *radiating pain*
☐ *light sensitivity*	☐ *diarrhea*	☐ *sleeping problems*
☐ *face flushed*	☐ *urinary problems*	☐ *numbness in legs*
☐ *reduced mobility*	☐ *bloating/gas*	☐ *stiffness*

☐ *Other:* _____
_____
_____

Birth History

What was the child's gestational age at birth? _____ *weeks*

Birth weight _____*lbs* _____*oz* *Birth length* _____ *inches*

Was your child's birth? ☐ *at home* ☐ *in a birthing center* ☐ *hospital*

Was the birth considered: ☐ *medical* ☐ *midwife* *Duration of birth:* _____ *hours*

Was child born: ☐ *cephalic (head first)* ☐ *breech (feet first)* ☐ *cesarean*

Were there any complications? ☐ *Yes* ☐ *No*

If yes, please explain: _____

_____

Assistances used during delivery:

☐ *Forceps* ☐ *Vacuum extraction* ☐ *C-section* ☐ *Episiotomy*

Was labor: ☐ *Spontaneous* ☐ *Induced*

Were medications or epidurals given to the mother during birth? ☐ *Yes* ☐ *No*

APGAR score: *At Birth* _____*/10* *After 5 minutes* _____*/10*

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ *Yes* ☐ *No*

If no, please explain _____

_____

At what age did the child:

Respond to sound _____ *Follow an object* _____

Hold up head _____ *Vocalize* _____

Sit alone _____ *Theethe* _____

Crawl _____ *Walk*_____

Does your child sleep on: ☐ *Front* ☐ *Back* ☐ *Side*

Do you consider your child's sleeping pattern normal? ☐ *Yes* ☐ *No* *Hours per day?* _____

If no, please explain: _____

Family Heath History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease, etc) that are present in:

Mother's family: _____

_____

Father's family: _____

_____

Siblings: _____

_____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. Falls, accidents, etc.) ☐ *Yes* ☐ *No*

If yes, please explain: _____

_____

Any evidence of birth trauma to the infant?

☐ *bruising* ☐ *stuck in birth canal* ☐ *respiratory depression*

☐ *odd shaped head* ☐ *fast or excessively long birth* ☐ *cord around neck*

Any falls from couches, beds, change tables, etc? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any traumas resulting in bruises cuts stitches or fractures? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any hospitalizations or surgeries? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any sports played? _____

Is there a school backpack used? ☐ *Yes* ☐ *No* *Is it* ☐ *heavy or* ☐ *light?*

Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

_____

Food/Juice intolerance? ☐ Yes ☐ No

If yes, what type: _____

_____

Is your child on any medications? ☐ Yes ☐ No

If yes, explain: _____

Has your child been on any medications in the past? ☐ Yes ☐ No

If yes, explain: _____

Any antibiotics given? ☐ Yes ☐ No

If yes, please explain: _____

Any pets at home ☐ Yes ☐ No

If yes, please explain: _____

Any smokers in the home? ☐ Yes ☐ No

During the mother's pregnancy:

Did the mother smoke? ☐ Yes ☐ No If yes, how much? _____

Did the mother drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Any illnesses during the pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

_____

Any supplements taken during pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Any drugs taken during pregnancy? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any ultrasounds? ☐ *Yes* ☐ *No* *How many?* _____

Reasons for being done: _____

_____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Psychosocial Stressors

Any difficulties with lactation? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any problems with bonding? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any behavioral problems? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Any night terrors, sleep walking, difficulty sleeping? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Does your child go to daycare? ☐ *Yes* ☐ *No*

If yes, age of child when began daycare? _____ *Average hours per week in daycare?* _____

Average hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ *Yes* ☐ *No*

If no, please explain: _____

_____

_____

_____

Thank you for completing this form. If there are any other questions or concerns which you have, please write them in the space below.

A+ Healthcare/ Marsden Family Chiropractic Informed Consent

We believe in making your health care needs a pleasurable experience. Your confidence in us as a health care provider is the best compliment we can receive. We will do our best to assist you in every way and pledge to you the best care we can deliver. In return, we ask for your full cooperation. The following will help you understand what to expect as a patient in our office.

1. *You will receive an examination and thorough history will be requested of you. From this, the Doctor will be better able to determine if you are a Chiropractic case.*
2. *If you are accepted as a patient, the Doctor may order x-rays of your condition. Those x-rays may be ordered in part or whole depending on the Doctor's recommendations. X-rays are a very important part of your evaluation and assist the Doctor in "knowing" rather than "guessing" your condition.*
3. *It is likely you will not be adjusted until the Doctor understands your condition fully and is sure she may be able to help you. From time to time additional examinations and tests may be needed to assist in proper analysis of your condition. If you are in extreme pain, the Doctor will assist you in its relief until your findings have been completed.*
4. *You will receive a complete report of findings as it pertains to your examination and x-rays. From this the Doctor will recommend a schedule of care that best suits your condition.* ***It is important you maintain all appointments that the Doctor has prescribed for you. If you miss an appointment, be sure and reschedule so that you do not lose any gained progress. Do not let symptoms be an indicator of your improvement. The Doctor will release you from care based on findings from the re-examinations and/or x-rays, not symptoms alone.***
5. *You will be scheduled for a Case Report that will educate you on how your health status relates to chiropractic. It is important that you do not miss this appointment so that you receive the most from your care.*

FINANCES

1. *If you are insured, we will be glad to verify that your coverage includes Chiropractic. Please inform the front desk of any insurance coverage you may have.*
2. *If you are not insured, we will work with you in any way possible. Our main concern is your health; therefore, we have payment plans to allow you to receive the care you need.*
3. ***IF YOU HAVE BEEN IN AN ACCIDENT, PLEASE INFORM THE FRONT DESK**. If we can be of service to you in any way, please let us know. We are here to help.*

Patient Name: _____ *Date:* _____/_____/_____

Patient Signature: _____

Witness: _____ *Date:* _____/_____/_____

Authorization for Care for a Minor (under 16 years of age)

*I hereby authorize Dr.*_____ *and whomever she/he may designate as his/her assistants to administer treatment during the recommended treatment plan, as he/she deems necessary to* _____*. I hereby authorize and consent to the chiropractic evaluation and care of my child.*

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____/_____/_____ *Witness:* _____