INNATE LIFE
CHIROPRACTIC

PEDIATRIC VITAL INFORMATION

Date_____

All information is strictly confidential and is only available for Innate Life Chiropractic staff to serve you best.

First Name:_____ Last Name:_____

Age:_____ Date of Birth: _____/_____/_____ Sex: □Male □Female

Parent/Guardian's Name:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email:_____

How were you referred to Innate Life Chiropractic?_____

Reason(s) for seeking services at Innate Life Chiropractic:_____

If this visit is for a specific condition, when did it begin? _____

How did the condition start? ▢ Suddenly ▢ Gradually ▢ Post-Injury

Is the condition: ▢ Getting Worse ▢ Improving ▢ Constant ▢ Intermittent ▢ Unsure

What makes the condition better?_____

What makes the condition worse? _____

Is the condition worse during certain times of the day? ▢ No ▢ Morning ▢ Afternoon ▢ Evening ▢ Night

How often do you experience this problem? □ Occasionally □ Intermittent □Frequent □ Constant

Is this condition interfering with: ▢ Work ▢ Sleep ▢ Hobbies ▢ Exercise ▢ Daily Routine

Have you ever had a similar condition? ▢ Yes ▢ No Please Explain_____

Please rate the severity of this problem on average: Low – 1 2 3 4 5 6 7 8 9 10 – High

Today: Low – 1 2 3 4 5 6 7 8 9 10 – High

Please mark the scale with the following indicators: 'X' = current level of health *'O'* = your *desired* level.

What goals do you and your child have? (Please check all that apply)

□Restore Health	□Maintain Health	□Symptom Relief/Temporary Relief
□More energy	□Better sleep	□Wellness & Prevention
□Improved Performance	□Cease medication	□Expand Level of Well-Being
□More joy and ease	□Reach full potential	□Keep up with siblings and friends

PERINATAL HISTORY

Type of Birth (check all that apply):

□Normal/Vaginal □Forceps □Breech □Epidural □Drug Induced □Vacuum Extraction

□Cord wrapped around neck □Hospital □Cesarean □Home

At how many weeks was your child born?_____ Birth Weight _____ Current Weight_____

Challenge(s) during pregnancy? _____

_____

Challenge(s) with labor/delivery? _____

_____

Present at Birth? □Jaundice (yellow) □Cyanosis (blue) □Congenital Anomalies:_____

APGAR score at birth:_____ APGAR score after 5 minutes: _____

Infant Feeding: □Breast □Bottle □Formula Quality of Sleep: □Good □Fair □Poor

Immunization History_____

Any childhood diseases?_____

Purpose of Last Visit to MD_____Date_____

OVERALL HEALTH

Has this child ever suffered from: (check all that apply)

☐Dizziness	☐Behavioral problems	☐Arm problems	☐ "Growing pains"
☐Diabetes	☐Backaches	☐Ruptures/hernias	☐Stomachaches
☐Anemia	☐Headaches/Migraines	☐Blood disorders	☐Chronic earaches/ear infections
☐Cold/Flu	☐Poor appetite	☐Heart troubles	☐Digestive disorders
☐Bed wetting	☐Rheumatic fever	☐Allergies	☐Diabetes/hypoglycemia
☐Fainting	☐Hyperactivity	☐Paralysis	☐Constipation
☐Seizures	☐Neck problems	☐Broken bones	☐Diarrhea
☐Asthma	☐Joint problems	☐Walking problems	☐Leg problems

☐Other: _____

Has your child ever had:

□ Surgery -- if so, when & for what condition(s)? _____

_____

□ Hospitalizations -- if so, when & for what condition(s):_____

_____

□ Chronic Illness(es) -- Explain: _____

_____

□ Emergancy Visits -- Explain: _____

_____

□ Other Injuries -- Explain: _____

_____

Family History_____

Has your child ever been involved in an auto accident □Yes □No –If yes please explain:_____

_____

What sports are/were they involved in? _____

_____

Medications your child currently takes:

□NSAID'S (Advil, etc.)	□Statins	□Blood Pressure	□Painkillers
□Muscle Relaxers	□Allergy	□Anti-Depressants	□Cold Medications
□Hormones	□Other: _____		

CHIROPRACTIC HISTORY

Has your child ever received Chiropractic care? □ Yes □ No Date of last adjustment? _____

Reason for previous chiropractic care?_____

What care plan was given?_____

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you?

_____

_____

CONSENT TO TREAT MINOR

I certify that I, _____, am the child's parent and/or legal guardian and responsible for making their health care decisions. I hereby authorize Dr. Nathan Gerowitz and whomever he may designate as his assistants to administer care, as he as deems necessary to my child _____. I also grant permission for Dr. Nathan Gerowitz to provide care for my child if I am not present.

Date _____/_____/_____ Signed_____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this practice to collect for services as they are rendered, unless other financial arrangements are made. If at any point, a patient must cancel the remaining of their care plan they are entitled to a refund of the remaining balance. A refund will not be given for services that have been previously rendered.

Patient Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each client understand both the objective and the method used. This will prevent any confusion or disappointment.

Health

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Adjustment

An adjustment is the specific application of forces to facilitate the body's clearing of vertebral subluxation.

Subluxation

Subluxations are neurological tension patterns, which interfere with the proper functioning of the nervous system and its ability to transmit mental impulses. This results in a lessening of the body's innate ability to express its infinite potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to clear major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to clear subluxations.

I, _____ (print name) have read and fully understand the above statements.

Patient Signature _____ Date _____