Your Child's Facts

Last Name: ______________________ **First Name:** ______________________ **Middle Initial:** ________

Address: ____ **Apartment #:** ________

City: ______________________ **State:** ______________________ **Zip:** ____________

Home #: __________________________ **Cell #:** __________________________

Email: ____

How did you find us? Patient *(who)*: ______________ Doctor *(who)*: ______________ Staff *(who)*: ______________

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: ______________

Date of Birth: ______ / ______ / ______ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

Employer: __________________________ **Work #:** ______________________ **Ext:** ________

Emergency Contact: ____________________ **Relationship:** ______________ **Phone #:** ______________

Primary Care Physician (PCP): ______________________________ **Phone #** (PCP): ______________

Are you currently taking any medications or supplements? *(Please include regularly used over the counter medications)*............................

Medication Name	Dosage and Frequency

Supplement Name	Dosage and Frequency

Do you have any medication, food, or environment allergies?

Medication, Food or Location	Reaction

Please list 3 major health goals in order of priority:

© 2017 Your Wellness Connection. This form updated May 24th, 2017

Recreational Activities, Sports Played, Hobbies		
1. ______	☐ past	☐ present
2. ______	☐ past	☐ present
3. ______	☐ past	☐ present

☐ **I do not want to know more about the benefits of becoming a Wellness Client.**

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These are often blank as a result of the nature/frequency of chiropractic care)*

FOR OFFICE USE ONLY

Height: ______ **Weight:** ______ **Blood Pressure:** ____/____ **Blood-type:** O A B AB

Doctor seen on this date (*circle all that apply*): MR SC SM SN SP ST

Documentation (*circle all that apply*): Scanned In Demo Entered Meds Entered Ins. Entered

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my medical information by Your Wellness Connection (YWC) and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of YWC. I understand that diagnosis or treatment of me by YWC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. YWC is not required to agree to the restrictions that I may request. However, if YWC agrees to a restriction that I request, the restriction is binding on YWC. I have the right to revoke this consent, in writing, at any time, except to the extent YWC has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review YWC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of YWC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of YWC. This Notice of Privacy Practices also describes my rights and the duties of YWC with respect to my medical information. YWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*This includes the consent to consult with your current, past and future providers outside Your Wellness Connection about your care, conditions and treatment plans.

______ **Today's Date:** ____/____/____

Patient or Personal Representative Signature:

______

Printed Name of Patient or Personal Representative:

© 2017 Your Wellness Connection. This form updated May 24th, 2017

Your Child's Life

P3

Name: ______________________ **Date of Birth:** ______________ **Date:** ______________

Mother's Health at Birth:

- Morning sickness ☐
- Indigestion ☐
- High or low blood pressure ☐
- Swollen ankles ☐
- Back pain ☐
- Groin pain ☐
- Diabetes ☐
- Anemia ☐
- Abnormal bleeding ☐
- Trauma/fall/vehicle accident ☐
- Hospitalized during pregnancy ☐
- Prescribed bed rest ☐
- Smoked ☐
- Consumed alcohol ☐
- Used over the counter drugs ☐

List: ______________________

- Used prescription medication ☐

List: ______________________

Birth to 3 Months:

Mark those that apply to your child as an infant.

- Medicated at birth ☐
- Vaccinated at birth ☐
- Formula fed ☐
- Other source ☐

List: ______________________

- Nursing difficulties ☐

List: ______________________

- One side feeding preference ☐
- Frequent spit-up after feeding ☐
- Smoker in household ☐
- Sleeps easily ☐
- Preferred sleeping position ☐
- Excessive crying/colic ☐
- Intestinal gas ☐
- Trauma, fall, accident ☐
- Noise when breathing ☐

4 Months and Up:

Mark those that apply to your child to age 2 years.

- Digestive problems ☐
- Food allergies ☐
- Takes vitamin supplements ☐
- Frequent respiratory infections ☐
- Tubes in ears ☐
- Frequent nightmares ☐
- Sleep walking ☐
- Trauma, fall, accident ☐
- Injuries, fractures, burns ☐
- Trips, falls easily ☐
- Medications ☐

List: ______________________

Birth History:

Check if you had any of the following.

- Hospital birth ☐
- Home birth ☐
- Planned C-section ☐
- Emergency C-section ☐
- Induced birth (Pitocin) ☐
- Forceps used ☐
- Vacuum extraction used ☐
- Epidural anesthesia ☐
- Other painkillers ☐

____

Infant Presentation

- Head ☐
- Face ☐
- Breech ☐
- Full term ☐
- Premature ☐

Weight: ______________

Length: ______________

Conditions:

List conditions in order of concern:

____

© 2017 Your Wellness Connection. This form updated May 24th, 2017

Your Child's History

P4

Name: ______________________ **Date of Birth:** ______________ **Date:** ______________

Health History

Issues
Mark those that apply:

- Back pain ☐
- Neck pain ☐
- Leg pain ☐
- Arm pain ☐
- Torticollis ☐
- Headaches ☐
- Ear infections ☐
- Tubes in ears ☐
- Recurring respiratory infections ☐
- Colic as an infant ☐
- Asthma ☐
- Allergies ☐
- Constipation ☐
- Bed-wetting ☐
- Skin problems (eczema, rashes) ☐
- Childhood diseases ☐
- Other ☐

List: ______________________

Trauma
Mark those that apply:

- Fall from bike, scooter ☐
- Fall down stairs ☐
- Fall from significant height ☐
- Motor vehicle accident ☐
- Trips and falls easily ☐
- Injuries (fracture, burn) ☐

Other: ______________________

Nutritional
Mark those that apply:

- Is a good eater ☐
- Likes all food ☐
- Has food allergies ☐
- Takes vitamin supplements ☐
- Is/was breast feed ☐
  - Length of time: ______________
- Drinks cow's milk ☐

Three favorite foods: ______________________

Emotional
Mark those that apply:

- Sleeps well at night ☐
- Takes daytime naps ☐
- Has nightmares ☐
- Sleep walks ☐
- Frequent temper tantrums ☐
- Cries a lot ☐

Other: ______________________

Developmental
Mark those that apply:

- Sit up unassisted ☐
  (age) ______________
- Rolls over ☐
  (age) ______________
- Crawls ☐
  (age) ______________
- Walks ☐
  (age) ______________

Environmental
Mark those that apply:

- Goes to day care ☐
- Smoker in household ☐

Immunizations
Mark those that apply:

- Has been immunized ☐
- Has had a reaction to immunization ☐

Is your child under medical care for a specific condition? ☐ Yes ☐ No

Please list the condition and care received. ______________________

© 2017 Your Wellness Connection. This form updated May 24th, 2017

Consent to Treatment of Minor Child

P5

Name: ______________________ **Date of Birth:** ______________________ **Date:** ______________________

I, (*print parent/guardian name*) ____

hereby authorize Dr. ____

and whomever she/he may designate in assistance to administer treatment as deemed necessary to my son/daughter

(*print child's name*) ____

Signature: ____ **Today's Date:** ______ / ______ / ______

Printed Name: ____

Witnessed: ____

© 2017 Your Wellness Connection. This form updated May 24th, 2017

Chiropractic Informed Consent

Name: ________________________ **Date of Birth:** ________________ **Date:** ________________

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, acupuncture, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

Adjustment: Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential current therapy: Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental traction therapy: This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Acupuncture: This ancient Chinese practice using the insertion of needles is used to restore proper energy flow through the body known as Chi, the vital life energy that flows through every living thing.

Exercise: The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

Signature: ________________________________ **Today's Date:** ______/______/______

Printed Name: ________________________________

© 2017 Your Wellness Connection. This form updated May 24th, 2017

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203 | www.YourWellnessConnection.com