Renewed Hope Chiropractic and Wellness
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Child Information (5-15 yrs)

Child's Name_____

Child's Date of Birth: _____ Gender: Male Female

Parent(s) Names _____

Address _____ City _____ State _____ Postal Code _____

Parents' E-mail Address _____

Home Phone _____ Mobile Phone _____

Whom may we thank for referring your child to this office? _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If they had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Often seemingly unrelated symptoms can manifest as other health concerns:
(Please circle if your child has had any of the following)

Headaches	Loss of taste	Weight gain	Upper back pain
Dizziness	Light sensitivity	Dental problems	Neck pain
Fainting	Face flushed	Fevers	Low back pain
Irritability	Bronchitis	Chest pressure	Stiffness
Depression	Pneumonia	Breast Pain	Reduced Mobility
Loss of balance	Difficulty breathing	Frequent colds	Numbness in leg(s)
Loss of concentration	Shortness of breath	Sinus congestion	Numbness in feet
Loss of memory	Asthma	Sore throat	Numbness in hand(s)
Ear buzzing	Urinary problems	Ear infection/pain	Weakness
Poor coordination	Constipation	Allergies	Muscle cramps
Vision changes	Diarrhea	Heartburn	Sleeping problems
Loss of smell	Weight loss	Bloating	Gas

Other: _____

Pregnancy and Birth History

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? Yes No Drink Alcohol? Yes No

Use Recreational Drugs? Yes No Fall ill during pregnancy? Yes No

Take Prescription Medications? No Yes Please list: _____

Were any supplements taken during the pregnancy? No Yes Please list: _____

LABOR / BIRTH

Type of birth? Vaginal: Cephalic (head first) Breech (feet first) C-Section

Was labor induced? Yes No Duration of labor? _____

Was there any of the following assistance needed during birth? Please circle all that apply.

Forceps Cesarean Vacuum Extraction Induction Assisted Traction/Head Turning

Was there any evidence of birth trauma to the infant? Circle all that apply:

Bruising Odd shaped head Stuck in birth canal Fast or excessively long birth Respiratory depression Cord around neck

Was your child subjected to any of the following? Circle all that apply:

Silver nitrate drops in eyes Incubation Vitamin K shot Separation from you Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? No Yes _____

Any falls or injuries down stairs, bicycle etc? No Yes _____

Any traumas resulting in fractures or stitches? No Yes _____

Any hospitalizations or surgeries? No Yes _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type_____ When_____ Hospitalized? Yes No

2. Type_____ When_____ Hospitalized? Yes No

3. Type_____ When_____ Hospitalized? Yes No

Has your child ever had x-rays taken? No Yes When? _____ Where?_____

Does your child play sports? No Yes which sport(s)? _____

Is school backpack used? No Yes Weight of backpack? _____kg/lbs

Approximate hrs spent at play per week? _____ Average hrs spent at computer/TV/video games per week? _____

CHEMICAL STRESS

Does your child have food allergies/ intolerances? No Yes, which _____

_____

The type of diet your child usually follows is classified as: _____

Do you have any concerns about your child's eating habits? No Yes, explain_____

_____

Please grade your child's dietary selections according to the following scale:

D - Consumes this daily W - Consumes this weekly **M** - Consumes this monthly **O** - Does not consume this

_____Eggs	_____Fasting	_____Fruit	_____Fish	_____Diet Food
_____ Organic Foods	_____Coffee	_____Beef	_____Weight Control Diet	_____Raw Vegetables
_____Soft Drink	_____Poultry	_____Artificial Sweetener	_____Whole Grains	_____Fried Foods
_____Seafood	_____Cooked vegetables	_____Refined Sugar	_____Dairy	_____Canned/Frozen vegetable

Have you chosen to give your child vaccinations? No Yes

If so what vaccinations were given and at what age?

_____

_____

Was there any of the following symptoms: Circle all that apply

Fever Un-consolable crying Irritability Arching of body Bowel disturbances

Feeding disturbances Drowsiness Other: _____

History of antibiotics? NO Yes how many courses of antibiotics has your child received? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____

EMOTIONAL STRESS

Night terrors, sleep walking, difficulty sleeping No Yes – explain _____

Quality of Sleep? Good Fair Poor Number of hours _____

Behavior problems? NO Yes, what problems _____

Does your child attend day care? No Yes From what age? _____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

_____

On father's side:

_____

Do siblings have any health concerns? No Yes, please describe:

_____

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.
Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.
Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. I understand that everybody has a different potential for wellness; thus, the maximum results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.
It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.
Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I, _____ have read and fully understand the above statements.
(PRINT NAME)
I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Swenson or other attending chiropractor.

_____
(SIGNATURE) (DATE) (WITNESS)

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms
(CHILD'S NAME)
of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.
(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995