LifeQuest
PHYSICAL MEDICINE AND REHAB

# Consent for treatment of a Minor

## (Without Parental/Guardian Supervision)

**I, _____ authorize LifeQuest Physical Medicine and Rehab to provide my son/daughter _____ health care as prescribed in their care plan without parental/guardian supervision. In case of emergency please contact:**

_____ _____

**Name/Relationship to patient** **Phone number**

_____ _____

**Parent or Guardian** **Date**

_____ _____

**Doctor** **Date**



1050 E. Ray Rd. Suite 4A, Chandler, AZ 85225 |Phone: (480) 659-2000

**PEDIATRIC HISTORY**

**Dear Parent,**

**It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. We look forward to working with you to build better health for you and your family. Please answer all that apply.**

**PATIENT NAME: _____ BIRTH DATE _____/____/____ AGE _____**

**S.S.# _____-_____-_____ SEX: M / F HEIGHT: _____ WEIGHT _____**

**NAME OF PARENTS/GUARDIANS: _____**

**ADDRESS: _____ CITY _____ STATE _____ ZIP _____**

**HOME PHONE: _____ WORK PHONE: _____**

**REASON FOR CONTACTING US? _____**

**OTHER DOCTORS SEEN FOR THIS CONDITION? Y / N NAME: _____**

**PHONE NUMBER: _____PRIOR TREATMENTS: _____**

**OTHER HEALTH PROBLEMS: _____**

**HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT/CONTACT TYPE SPORTS (SOCCER FOOTBALL, GYMNASTICS, BASEBALL, CHEER LEADING, MARTIAL ARTS, ETC.)? Y / N**

**HAS YOUR CHILD BEEN INVOLVED IN A CAR ACCIDENT? Y / N LIST:_____**

**HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS OR HAVE THEY EVER BEEN HOSPITALIZED? Y / N LIST: _____**

**ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN HAVE HAD A FALL FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (BED, CHANGING TABLE, STAIRS, ETC) WAS THIS THE CASE WITH YOUR CHILD? Y / N LIST: _____**

**NAME OF OBSTETRICIAN/MIDWIFE: _____PHONE: _____**

**COMPLICATIONS DURING PREGNANCY? Y / N _____**

**# OF ULTRASOUNDS DURING PREGNANCY? _____ MEDICATIONS DURING PREGNANCY/DELIVERY? Y/N Please list:_____**

**LOCATION OF BIRTH: HOSPITAL BIRTHING CENTER HOME OTHER:_____**

**BIRTH INTERVENTION: FORCEPS VACCUM EXTRACTION C-SECTION**

**Child's head bruised, swollen, malformed?**

**APGAR SCORE _____ BIRTH WEIGHT _____ LB _____ OZ BIRTH LENGTH _____"**

**FEEDING HISTORY**

**BREAST FED: Y / N HOW LONG: _____ FORMULA FD: Y / N HOW LONG: _____**

**INTRODUCED SOLIDS AT: _____ MONTHS COWS MILK AT _____ MONTHS**

**ALLERGIES OR INTOLERANCE: Y / N LIST: _____**

**DOES YOUR CHILD HAVE/HAD ANY OF THESE PROBLEMS? (please circle)**

**EAR INFECTIONS TONSILLITIS STREP THROAT BED WETTING DIGESTIVE DISORDERS DIARRHEA CONSTIPATION HYPERACTIVITY ADD/ADHD ASTHMA BLOOD DISORDERS HEADACHES SEIZURES GROWING PAINS UPPER RESPIRATORY INFECTIONS BEHAVIORAL PROBLEMS OTHER:_____**

**VACCINATION HISTORY: REGULAR / FULL SERIOUS OR HALF / PARTIAL SERIES**



**CHICKEN POX: Y / N AGE _____ MEASLES: Y / N AGE_____ MUMPS: Y / N AGE _____**

**RUBELLA: Y / N AGE _____ DPT: Y / N AGE_____ HEPATITIS B: Y / N AGE _____**

**OTHER: _____**

**HAS YOUR CHILD HAD ANY OF THE DISEASES VACCINATED FOR? Y / N LIST: _____**

**VACCINE REACTIONS (please circle): UNEXPLAINED ALLERGIES, HIVES OR RASH, HIGH FEVER, VOMITING, SWOLLEN LIMBS, SWOLLEN SHOT SITE, PROBLEMS BREATHING HIGH PITCH SCREAM OR CRY, SEIZURES OR CONVULSIONS. *THESE MAY OCCUR WITHIN HOURS TO SEVERAL DAYS AFTER VACCINATION.***

**HAVE/DID YOU NOTICE ANY OF THESE REACTIONS? Y / N**

**OTHER:_____**

**I HEAR BY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO EXAMINE/ADMINISTER TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.**

**PARENT/GUARDIAN SIGNATURE: _____ DATE: _____**

**WITNESS SIGNATURE: _____ DATE: _____**

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-OFFICE USE ONLY-

## EXAMINATION

| **Posture** | |
|---|---|
| **HEAD TILT** | **R/L** |
| **HEAD SHIFT** | **R/L** |
| **HEAD ROTATION** | **R/L** |
| **HEAD** | **A/P** |
| **HIGH SHOULDER** | **R/L** |
| **HIGH HIP** | **R/L** |

| **PALPATION** | |
|---|---|
| **PAIN/TENDER** | **C T L P** |
| **EDEMA** | **C T L P** |
| **SPASM** | **C T L P** |
| **EXTREMITY** | **_____** |
| | **_____** |

| **REFLEXES** | |
|---|---|
| **BICEPS** | **R _____/_____L** |
| **BRACHIORADIALIS** | **/** |
| **TRICEP** | **/** |
| **PATELLAR** | **/** |
| **ACHILLES** | **/** |

| | |
|---|---|
| **SUPINE SHORT LEG** | **R / L** |
| **DEREFIELD LEG** | **R / L NEG** |
| **SACRAL LEG** | **SAR / SAL** |

| | |
|---|---|
| **FORAMINALK COMPRESSION** | **R / L / EXT** |
| **SHOULDER DEPRESSOR** | **R / L** |
| **KEMPS** | **R / L** |

**CERVICAL ROM**
**FLEX ____ EXT ____ RLF ____ LLF____ RROT ____ LROT ____**
**LUMBAR ROM**
**FLEX ____ EXT ____ RLF ____ LLF____**

**X-RAYS:**

**RX:_____**

**Dr Signature: _____ Date: _____**