



**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

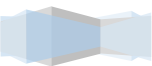
Phone number

Parent or Guardian

Date

Doctor

Date



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: _____

**-OFFICE USE ONLY-
EXAMINATION**

<p align="center">Posture</p> <p>HEAD TILT R/L HEAD SHIFT R/L HEAD ROTATION R/L HEAD A/P HIGH SHOULDER R/L HIGH HIP R/L</p>	<p align="center">PALPATION</p> <p>PAIN/TENDER C T L P EDEMA C T L P SPASM C T L P EXTREMITY _____ _____</p>	<p align="center">REFLEXES</p> <p>BICEPS R _____/_____ BRACHIORADIALIS / TRICEP / PATELLAR / ACHILLES /</p>
<p>SUPINE SHORT LEG R / L DEREFIELD LEG R / L NEG SACRAL LEG SAR / SAL</p>	<p>FORAMINALK COMPRESSION R / L / EXT SHOULDER DEPRESSOR R / L KEMPS R / L</p> <p>CERVICAL ROM FLEX ___ EXT ___ RLF ___ LLF ___ RROT ___ LROT ___ LUMBAR ROM FLEX ___ EXT ___ RLF ___ LLF ___</p>	

X-RAYS:

RX: _____

Dr Signature: _____ **Date:** _____

