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: ____________________________________

HOW DID YOU HEAR ABOUT US? EVENT YELP GOOGLE WEBSITE RADIO PATIENT REFERRAL

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:____

PEDIATRICIAN NAME/OFFICE NAME: ____

ADDRESS: _______________________________________ PHONE ______________________

WOULD YOU LIKE OUR PHYSICANS TO COMMUNICATE YOUR CHILD'S CONDITION AND COURSE OF CARE WITH THEIR PEDIATRICIAN? Y / N

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

Posture		PALPATION		REFLEXES	
HEAD TILT	R/L	PAIN/TENDER	C T L P	BICEPS	R _______/_______L
HEAD SHIFT	R/L	EDEMA	C T L P	BRACHIORADIALIS	/
HEAD ROTATION	R/L	SPASM	C T L P	TRICEP	/
HEAD	A/P			PATELLAR	/
HIGH SHOULDER	R/L	EXTREMITY ____________________		ACHILLES	/
HIGH HIP	R/L	____________________________			

SUPINE SHORT LEG	R / L	FORAMINALK COMPRESSION	R / L / EXT
		SHOULDER DEPRESSOR	R / L
DEREFIELD LEG	R / L NEG	KEMPS	R / L
SACRAL LEG	SAR / SAL	**CERVICAL ROM**	
		FLEX ____ EXT ____ RLF ____ LLF____ RROT ____ LROT ____	
		LUMBAR ROM	
		FLEX ____ EXT ____ RLF ____ LLF____	

X-RAYS:

RX:

___

Dr Signature: ______________________________ Date: ______________