CLOVERLEAF CHIROPRACTIC CLINIC

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CHILDREN INFORMATION CARD

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS.

DATE

FIRST NAME	MIDDLE NAME	LAST NAME

STREET ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	AGE	PRIMARY LANGUAGE	SEX ☐ Male ☐ Female	Social Security #	HOW DID YOU HEAR ABOUT US?

PARENT'S NAME:	PARENT'S HOME PHONE #	PARENT'S PHONE #	PARENT'S PHONE #

Have your child ever had chiropractic care before? ☐ No ☐ Yes Where?	Do You Have any Insurance to Cover for your child's care? ☐ No ☐ Yes Name of Insurance?

REASON FOR THIS VISIT

Purpose of this Visit:	Is the purpose of this appointment related to: ☐ sports ☐ auto ☐ fall ☐ home injury ☐ chronic discomfort ☐ other		
When did this condition begin?	**How did it begin?**	**WAS IT?** ☐ Gradual ☐ Sudden	**Has the condition** ☐ stayed the same ☐ gotten worse ☐ comes and goes
Does the condition interfere with ☐ sleep ☐ daily routine ☐ Other Explain:	**Has this condition occurred before?** ☐ Yes ☐ No Explain:	**Have you seen other doctors for this condition?** ☐ Yes ☐ No	
Dr's Name:	Type of Treatment:	Results:	

MOTHER'S PREGNANCY AND LABOR

During the pregnancy, did the mother take any medication? ☐ Yes ☐ No List Medications Taken:	During the pregnancy, did the mother smoke or consumed alcohol? ☐ Yes ☐ No	During the pregnancy, did the mother experience any illness? ☐ Yes ☐ No Describe:
Approximately how long did labor last?	**Was labor chemically assisted?** ☐ Yes ☐ No	**Was labor doctor assisted?** ☐ Yes ☐ No
Was a C-Section Performed? ☐ Yes ☐ No	**Were forceps or vacuum extraction used?** ☐ Yes ☐ No	**Did the delivery doctor pull or twist the baby during delivery?** ☐ Yes ☐ No

Was the delivery premature? ☐ Yes ☐ No If Yes, At what month and weight? _____ Month _____ Weight	Did the child experience any of the following immediately after birth: ☐ Jaundice ☐ Respiratory Problems ☐ Feeding Problems ☐ Displaced or Broken Joins ☐ Other Condition (s):

CHILD'S HEATH HISTORY

Please check each condition that the child has now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care of your child.

☐ Vision Problems	☐ Ear Problems	☐ Tubes in Ears	☐ Skin Problems	☐ Colic	☐ Headaches	☐ Asthma
☐ Digestive Problems	☐ Hyperactivity	☐ Constipation	☐ Breathing Problems	☐ Pink Eye	☐ Irritability	☐ Allergies
☐ Attention Problems	☐ Frequent Colds	☐ Bed Wetting	☐ Sleeping Disorders	☐ Other:		

PEDIATRIC CHIROPRACTIC EXAMINATION

COMPLAINT	ONSET	Length of time
#1	☐ Gradual ☐ Sudden	
#2	☐ Gradual ☐ Sudden	
#3	☐ Gradual ☐ Sudden	

ADDITIONAL COMMENTS:

ORTHO

☐ Kemp Test	LT	RT	BILAT
☐ Bragard Test	LT	RT	BILAT
☐ Lasegue Test	LT	RT	BILAT
☐ Shoulder Depressor	LT	RT	BILAT
☐ Foramina Compression	LT	RT	BILAT
☐ Low Extended Extr	LT	RT	BILAT

INFANT REFLEXES

Rooting	A	P
Sucking	A	P
Blink	A	P
Acoustic Blink	A	P
Moro	A	P
Galant's	A	P
Tonic Neck	A	P
Neck Righting	A	P
Palmer Grasp	A	P
Digital Response	A	P
Vertical Suspension	A	P
Placing Response	A	P
Parachute Response	A	P
Babkin	A	P

RESTRICTIONS

School / Sport Restriction	☐ YES ☐ No
Restriction from _____ to _____	

ROM

☐ Cerv. Flexion	LT	RT	BILAT
☐ Cerv extension	LT	RT	BILAT
☐ Cerv Lat Flexion	LT	RT	BILAT
☐ Cerv. Rotation	LT	RT	BILAT
☐ DL Flexion	LT	RT	BILAT
☐ DL Extension	LT	RT	BILAT
☐ DL Lat. Flexion	LT	RT	BILAT
☐ DL Rotation	LT	RT	BILAT

MUSCLE TESTING

Upper extremities LT 012345 RT 012345

Lower extremities LT 012345 RT 012345

George / Klein

Symptoms – headache _____ vomiting _____

Nausea _____ Dilated Pupils _____

Dizziness _____ Nystamus _____

PHYSICAL

Age:	Height:	Weight:	B/P:

Gross Dental	☐ Normal	☐ Abnormal
Head/Scalp/Skin	☐ Normal	☐ Abnormal
Eyes/Ear/Nose/Throat	☐ Normal	☐ Abnormal
Chest/Lungs/Heart	☐ Normal	☐ Abnormal
Abdomen	☐ Normal	☐ Abnormal
Postural Assessment	☐ Normal	☐ Abnormal

	SPINAL ANALYSIS	PALPATION ANALISIS	
		LT	RT
At			
Ax			
3C			
4			
5			
6			
7			
1D			
2			
3			
4			
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7			
8			
9			
10			
11			
12			
1L			
2			
3			
4			
5			
SAC			
R ILI			
L ILI			
Coc			

LEG CHECK

RT_____ LT _____

FOOT FLARING

INTERNAL	LT	RT	BILAT
EXTERNAL	LT	RT	BILAT

CERVICAL SUPPORT	☐ YES ☐ No
LUMBAR SUPPORT	☐ YES ☐ No
PREGNANT	☐ YES ☐ No

ADDITIONAL NOTES:

Dr. Daniel Abeckjerr, D.C.

CLOVERLEAF CHIROPRACTIC CLINIC

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic or those working in the clinic or office who now or in the future treat me while employed by, working or associated with as a backup doctor for the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including but not limited to fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read, or have had read to me, the above consent, I have had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CONSENT FOR MINOR CHILD OR LEGALLY/PHYSICALLY INCAPACITATED

PRINT NAME OF PATIENT	X **PRINT NAME OF REPRESENTATIVE**
RELATION /AUTHORITY OF REPRESENTATIVE	X **SIGNATURE OF PATIENT'S REPRESENTATIVE**

PREGNANCY

I hereby authorize X-rays to be taken which are considered to be necessary. **I HEREBY CERTIFY THAT I AM NOT PREGNANT NOR DO I BELIEVE TO BE PREGNANT.** I further understand that if I am pregnant and I do not inform the doctor of same that radiation could cause permanent health problems or risks to my unborn child. Furthermore, I understand that the **clinic or office will not be held responsible for any of** the health problems or risks that my unborn child may suffer if I do not inform the doctor that I am pregnant or believe to be pregnant.

DATE	X SIGNATURE

NOTICE OF PATIENT PRIVACY PRACTICES

I have read a copy of the clinic/office's Notice of Patient privacy Practices.

PRINT NAME	X SIGNATURE	DATE

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