Child Health Assessment Profile

Child's Name: _____ Birthdate: ____ / ____ / ____ Age: _____

Address: _____
(street) (city) (state) (zip code)

Parent's / Guardian's names: _____
Home phone: ( ) _____
Office phone: ( ) _____
Cell phone: ( ) _____
Email: _____

What prompted you to bring your child in for care here **today**?

_____

Have you seen other doctors for this **same** condition/concern? ❑ pediatrician ❑ naturopath ❑ specialist
Did they help? **Y / N**

Does your child experience any health problems? **Y / N**
If Yes, please describe: _____

_____

Has your child's spine ever been professionally evaluated? **Y / N** ❑ by chiropractor ❑ by pediatrician
When? _____

Part I: Physical Stresses

Please check ALL that apply.

Early Physical Stresses

	YES	No	Comments:
Were there any complications during this child's **pregnancy**?	❑	❑	
Did you choose to have any ultrasounds performed during pregnancy?	❑	❑	
Did you have any falls or accidents while pregnant with this child?	❑	❑	
Were there any complications with this child's **delivery**?	❑	❑	
Was there any type of birth intervention used during delivery? (ie. Forceps, vacuum extraction, ceasarian section)	❑	❑	

Childhood Physical Stresses

	YES	No	Comments:
Has your child ever had a fall from a high place? (ie. bed, stairs, etc.)	❑	❑	
Is or has your child been involved in any high impact sports? (ie. Soccer, football, gymnastics, martial arts, roller sports, etc.)	❑	❑	
Has your child ever been involved in a car accident?	❑	❑	
Has your child experienced any other traumas not described above?	❑	❑	
Has your child had any hospitalizations or surgeries?	❑	❑	

Childhood Diseases and/or Conditions:

❑chicken pox	❑chronic colds	❑digestive problems	❑temper tantrums
❑rubella / measles / mumps	❑ear infections	❑bed wetting	❑cystic fibrosis
❑whooping cough	❑colic	❑seizures	❑muscular dystrophy
❑rubeola	❑asthma / allergies	❑ADD / ADHD	❑other _____

Part II: Mental / Emotional Stresses

If your child is old enough, please allow them to help you fill out this section.

	Few		Several		Many		Never	Comments:
	Past	Present	Past	Present	Past	Present		
School stress / pressure	❑	❑	❑	❑	❑	❑	❑	
Parents separated / divorced	❑	❑	❑	❑	❑	❑	❑	
Feel depressed / bored	❑	❑	❑	❑	❑	❑	❑	
Pressure to fit in with friends	❑	❑	❑	❑	❑	❑	❑	
Significant move	❑	❑	❑	❑	❑	❑	❑	
Family stress	❑	❑	❑	❑	❑	❑	❑	
Loss of loved one	❑	❑	❑	❑	❑	❑	❑	

Part III: Chemical and Dietary Stress

	DAILY		WEEKLY		MONTHLY		YEARLY		NOT AT ALL
	Past	Present	Past	Present	Past	Present	Past	Present	
alcohol during pregnancy	❑	❑	❑	❑	❑	❑	❑	❑	❑
tobacco use during pregnancy	❑	❑	❑	❑	❑	❑	❑	❑	❑
antibiotics and medicines	❑	❑	❑	❑	❑	❑	❑	❑	❑
childhood vaccinations	❑	❑	❑	❑	❑	❑	❑	❑	❑
sporadic eating	❑	❑	❑	❑	❑	❑	❑	❑	❑
diet food / artificial sweeteners	❑	❑	❑	❑	❑	❑	❑	❑	❑
meat products	❑	❑	❑	❑	❑	❑	❑	❑	❑
dairy products	❑	❑	❑	❑	❑	❑	❑	❑	❑
soda	❑	❑	❑	❑	❑	❑	❑	❑	❑
processed / fried foods	❑	❑	❑	❑	❑	❑	❑	❑	❑

Notes:

Infinite Healing Arts Center
Consent For Purposes Of Care, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to Infinite Healing Arts Center.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing care to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or care of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out care, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner. I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. The Notice of Privacy Practices for Practitioner is also posted in the reception area of this office. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent or asking for one at the time of my next appointment.

Terms Of Acceptance

When an individual seeks care in our office and we accept them as a patient or member of our practice, it is essential that we are both clear with respect to our goals and responsibilities. We understand that many people first come to our office seeking relief from some form of pain or discomfort. It is our first priority to make sure that each person knows whether we can be of service to help them or not.

We recognize that there is an innate ability of the body to be healthy, whole, and self-regulating and we understand that a body in a state of stress physiology may exhibit altered posture and/or spinal curves, muscle tension, and alterations in various functions of the nervous system.

We recognize vertebral subluxations as any spinal interference associated with stress physiology and an alteration of nerve function, resulting in a lessening of the body's innate ability to express its optimal health potential. We understand that care in our office helps the individual to eliminate such spinal interference and vertebral subluxations and to develop a healthier spine and greater nervous system integrity in each individual, regardless of the presence or absence of symptoms.

We do not offer to diagnose or treat any disease or symptom. We only offer to assess your loss of spinal and neural integrity in relationship to any spinal subluxations that may exist. If you have symptoms, a condition, or some disease about which you are concerned, we suggest you consult with another health care provider whose practice is geared towards such differential diagnosis and treatment. We may be able to assist you with an appropriate referral. Recommendations or suggestions regarding any medicines you are taking or wish to take remains the practice of medicine, which is outside our scope of practice. We feel that it is your responsibility to discuss this matter with your physician in relation to your current and long-term desires concerning your health and well being.

We are in agreement with the World Health Organization as they define health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. We choose to help each member of our practice achieve greater levels of spinal health, nerve system integrity, and overall quality of life and well being.

By my signature below, I acknowledge that I have read the above "Consent for Purposes of Care, Payment & Healthcare Operations" and the "Terms of Acceptance" and understand the contents of both. I choose to receive care for myself and/or my child for the above stated objectives of achieving greater levels of spinal health, nerve system integrity and wellness.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority