PEDIATRIC (0-17)

7815 3rd St. N, Suite 102, Oakdale, MN 55128
651.400.7777

PATIENT MR# ______________ DATE OF FIRST VISIT: _____ /_____ /_____

Thank you for choosing Big Idea Chiropractic. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals. We will require a photocopy of your DRIVER'S LICENSE (or government identification) and INSURANCE CARD for our records. We comply with all federal privacy standards. As such, all information you provide is confidential.

PATIENT INFORMATION

First Name: ____________________ Middle Initial: ______ Last Name: ______________________

Nickname: ____________________ DOB: _____ /_____ /_____ Age: _______ Gender: ________

Address: ____ Apt# ______________

City: ____________________________________ State: ______________ Zip: ________________

Name of Parent/Guardian: ____

Relationship to Patient: ____

Email: ____

Cell # _________________________________ Home # ________________________________

What is your preferred method of communication? Email Text Call

Would you like to receive email reminders regarding appointments? Yes No

Would you like to receive text reminders regarding appointments? Yes No

How did you find Big Idea Chiropractic? ____

If referred, whom may we thank? ____

HEALTH HISTORY OF CHILD/TEEN

Please check all that apply regarding your child or teen's birth (if known):

Pre-term   Vaginal   Breech   Cesarian   Forceps   Vaccuum

Has he or she had any major illnesses?   Yes   No

Is yes, please explain: ______________________________

____

Has he or she had any surgeries?   Yes   No

If yes, please explain: ______________________________

____

Has he or she had any serious falls or accidents?   Yes   No

If yes, please explain: ______________________________

____

Has he or she suffered any emotional traumas?   Yes   No

If yes, please explain: ______________________________

____

Has he or she been involved in any motor vehicle accidents?   Yes   No

If yes, please explain: ______________________________

____

Has he or she suffered any concussions?

Never   One time only   Multiple times   I think so, but it was never evaluated

PREVIOUS CHIROPRACTIC CARE

Has he or she been under chiropractic care before?

Never   One time only   A few times only   Once in a while   Regularly

If yes, what was the reason? ______________________________

What were the results?

He/she got worse   No change   Fair   Good   Excellent

What is the approximate date of his or her last chiropractic adjustment? ______________

Do you have any reservations regarding chiropractic care?   Yes   No

If yes, please explain: ______________________________

____

MEDICATIONS & SUPPLEMENTS

Please list any prescription medications, over-the-counter medications, and supplements your child or teen is currently taking. Include the reason and how long he or she has been taking it.

1. Name: ______________ Reason: ______________

For how long? ______________

2. Name: ______________ Reason: ______________

For how long? ______________

3. Name: ______________ Reason: ______________

For how long? ______________

4. Name: ______________ Reason: ______________

For how long? ______________

5. Name: ______________ Reason: ______________

For how long? ______________

REVIEW OF SYSTEMS

Please check all that apply

- Abuse/Neglect
- Acid Reflux
- Anemia
- Ankles/Feet Pain
- Anxiety
- Appendicitis
- Arching/Flailing
- Asthma
- Autism
- Bed Wetting
- Belching/Gas
- Bruise Easily
- Cancer
- Can't Control Urine
- Chicken Pox
- Chronic Cough
- Cold Sores
- Colic
- Concentration-Lacking
- Constipation
- Croup
- Deafness
- Decreased Energy
- Depression
- Diabetes (Type 1 or 2)
- Diarrhea
- Difficult Digestion
- Difficulty Bonding
- Difficulty Breathing
- Difficulty Crawling/Walking
- Dizziness
- Dyslexia
- Earache
- Ear Infections
- Eczema
- Elbow Pain
- Excessive Crying
- Eye Pain
- Frequent Colds/Flus
- Growing Pains
- Hands/Wrist Pain
- Hay Fever
- Headaches/Migraines
- Heart Condition
- High/Low Blood Pressure
- Hip Pain
- Hives or Allergy
- Hoarseness
- Hyperactivity
- Increased Sleep
- Increased/Decreased Appetite
- Irritability
- Itching or Rashes
- Jaw/TMJ Pain
- Knee Pain
- Leg Pain
- Loss of Sleep
- Loss of Weight
- Lower Back Pain
- Nasal Obstruction
- Neck Pain
- Night Terrors/ Sleepwalking
- Nosebleeds
- Painful Urination
- Pleurisy
- Pneumonia
- Rapid/Slow Heart Rate
- Scoliosis
- Shoulder Pain
- Sinus Infections
- Sore Throat
- Tonsillitis
- Upper Back Pain
- Weight Gain
- Wheezing
- Whooping Cough

DESCRIPTION OF CONDITION

What condition lead you to seek chiropractic care?

____

____

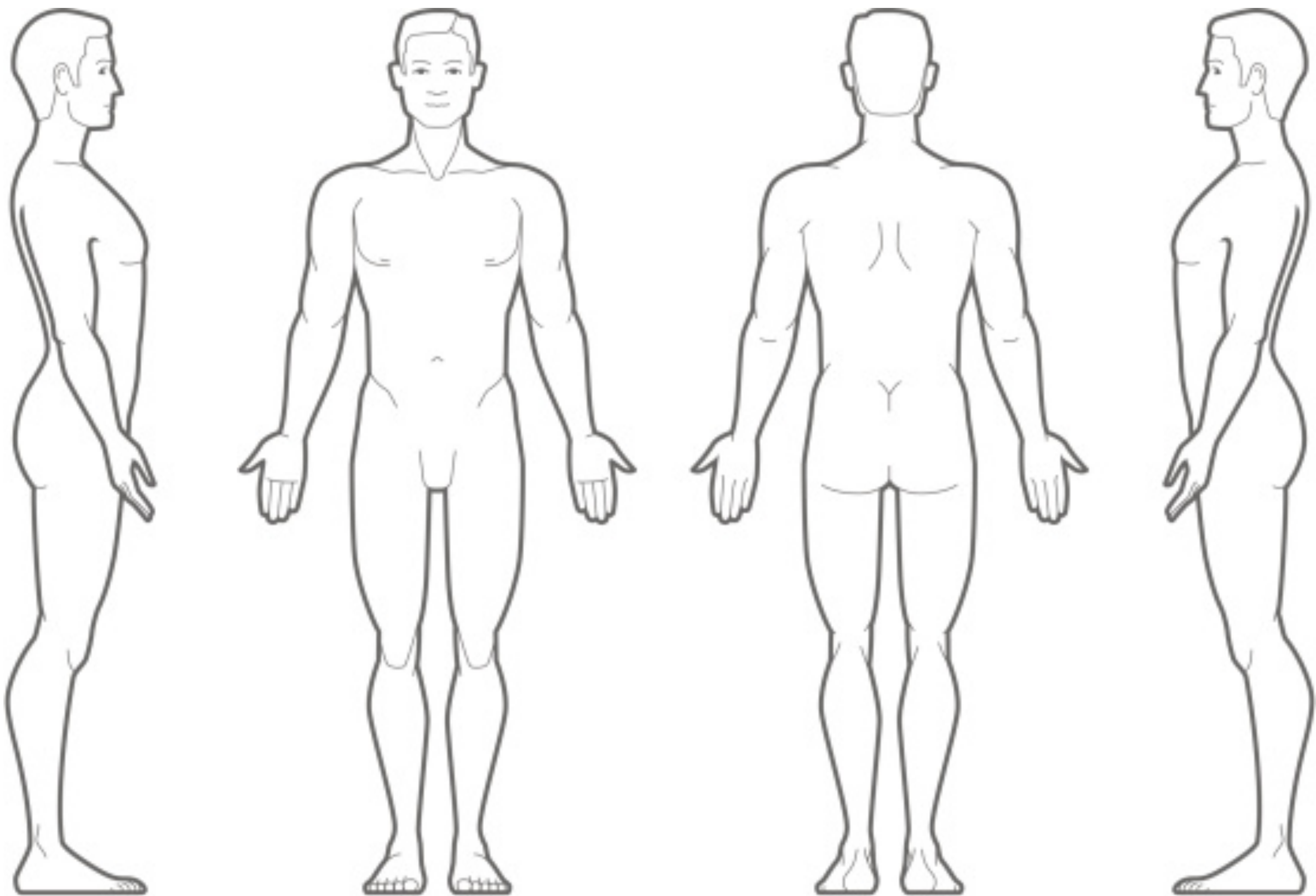
When did you first notice this condition?

____

What were you doing when you first noticed this condition?

____

Place an "X" on the diagram below where you are experiencing symptoms:



Do the symptoms radiate or travel to another area? Yes No

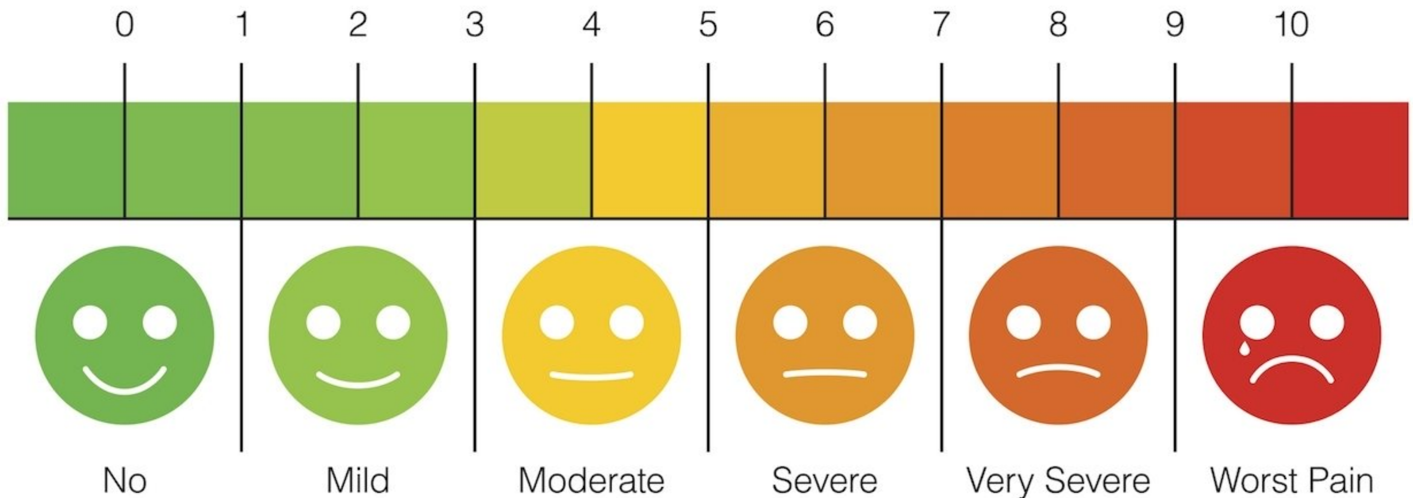
If yes, please describe: ____

Are you experiencing pain with this condition? Yes No

If yes, how would you describe the sensation of the pain? (mark all that apply)

Sharp Dull Achy Throbbing Burning Pins & Needles Numb

Please rate the intensity of your pain (circle a number):



How frequently do you experience symptoms?

Intermittently (0-25% of day)	Occasionally (26-50% of day)	Frequently (51-75% of day)	Constantly (76-100% of day)

What makes your condition worse?

____

____

What makes your condition better?

____

____

What movements or activities are more difficult due to this condition?

____

____

Have you had this condition before? Yes No

INFORMED CONSENT FOR CHIROPRACTIC CARE TO A MINOR

CHIROPRACTIC ADJUSTMENTS

The primary service rendered at Big Idea Chiropractic PLLC to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interferences to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments are done by hand and may include either spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

OTHER PROCEDURES

A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, etc. Radiology is the use of x-rays to gain an inside perspective of the human body that cannot be obtained from a physical examination. By signing this form, you certify Dr. Clay Larson, DC has permission to perform an x-ray evaluation. **To the best of your knowledge, you are not pregnant and have been advised that x-rays can be harmful to an unborn child.**

CONSENT TO CARE OF A MINOR

By signing this form, you authorize Dr. Clay Larson, DC to administer care as he deems necessary to your minor dependent.

BENEFITS OF CHIROPRACTIC CARE

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and many others. It must be remembered that different people respond differently to chiropractic care. Different people have pre-existing conditions and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given.

RISKS INHERENT WITH CHIROPRACTIC CARE

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, or costovertebral strains and separations. Some patients feel some stiffness and/or soreness following the first few days of treatment. Dr. Clay Larson, DC will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform him of any conditions that would not otherwise come to his attention.

PAYMENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in receiving reimbursement from my insurance company which will be sent directly to me. However, I clearly understand and agree I am personally responsible for payment of any services rendered to me and charged directly to me.

____ Date: ____________________

Signature of Patient's Legal Guardian*

____

Signer's Printed Name

* By signing for a minor patient, I hereby state I am his or her legal guardian and my parental rights have not been revoked by a court of law

PATIENT HEALTH INFORMATION CONSENT

At Big Idea Chiropractic PLLC, we want you to know how your Patient Health Information (PHI) is going to be used and your rights concerning those records. Before you begin any services at our clinic, you must read and sign this consent form stating you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic clinic to use his or her Patient Health Information (PHI) for the purpose of chiropractic services, payment, and coordination of care. For example, the patient agrees to allow Big Idea Chiropractic PLLC to submit requested PHI to the health insurance company (or companies) provided to it by the patient for the purpose of payment. Be assured this clinic will limit the release of all PHI to the minimum required.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient my request to know what disclosures have been made and submit in writing any further restrictions on the use of his or her PHI. Please note, however, this clinic is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given this patient at this clinic.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures within this clinic. Big Idea Chiropractic PLLC has taken all known precautions to assure records are not readily available to those who do not need access to them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policy procedures.

7. If the patient refuses to sign this consent for the purpose of chiropractic services, payment, and coordination of care, Big Idea Chiropractic PLLC has the right to refuse care.

____ Date: ____________________

Signature of Patient's Legal Guardian*

____

Signer's Printed Name

* By signing for a minor patient, I hereby state I am his or her legal guardian and my parental rights have not been revoked by a court of law