# VANELLA CHIROPRACTIC

*"Helping families get well and stay well for a lifetime."*

| | | | |
|---|---|---|---|
| Child's Name | | | Sex: □ M □ F |
| DOB: | AGE: | Height: | Weight: |
| Parent/Guardian's Name: | | | |
| Address | | | |
| Email: | | Cell Phone: | |
| How did you hear about us? | | | |
| Who is your primary care physician? | | | |
| Are you also receiving care from any other health professionals? □ Yes □ No<br>If yes, please name them and speciality: | | | |
| Please list any drugs/medications/vitamins/herbs/other your child is taking: | | | |

**CURRENT HEALTH CONDITIONS**

| |
|---|
| What health condition(s) bring your child to be evaluated by a chiropractor? |
| |
| |
| Has your child received care for this condition before? □ Yes □ No<br>If yes, please explain: |
| When did the condition(s)first begin? |
| How did the problem start? □ Suddenly □ Gradually □ Post injury |
| Is this condition □ Getting worse □ Improving □ Intermittent □ Constant □ Unsure |
| What makes the problem better? |
| What makes the problem worse? |

**HEALTH GOALS FOR YOUR CHILD**

| | |
|---|---|
| What are your top 3 health goals for your child: | What would you like to gain from chiropractic care? |
| 1 | □ Resolve existing condition |
| 2 | □ Overall wellness |
| 3 | □ Both |
| Have you ever visited a chiropractor? □ No □ Yes, what is their name? | |
| What is their specialty? □ Pain relief □ Physical therapy & rehab □ Nutritional □ Subluxation □ Other | |

**PREGNANCY & FERTILITY HISTORY (please tell us about your pregnancy)**

| |
|---|
| Any fertility issues? □ No □ Yes, please explain: |
| Did mother smoke? □ No □ Yes, how many per week? |
| Did mother drink? □ No □ Yes, how many per week? |
| Did mother exercise? □ No □ Yes, please explain: |
| Was mother ill? □ No □ Yes, please explain: |
| Any ultrasounds? □ No □ Yes, please explain: |
| Please explain any notable episodes of mental or physical stress during your pregnancy: |
| |
| Please explain any other concerns or notable remarks abour your child's conception or pregnancy? |
| |

## LABOR & DELIVERY HISTORY

Child's birth was □ Natural vaginal birth □ Scheduled C-section □ Emergency C-section

At how many weeks was your child born? Doctor/Obstetrician's name:

Child's birth was □ At home □ At a birthing center □ At a hospital □ Other

Please check any interventions or complications:
□ Breech □ Induction □ Pain meds □ Epidural □ Episiotomy □ Vacuum extraction □ Forceps □ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery?

Child's birth weight: Child's birth height:

APGAR score at birth: APGAR score after 5 minutes:

## GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? □ No □ Yes, how long? Difficult with breastfeeding? □ No □ Yes

Did they ever use formula? □ No □ Yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation? □ No □ Yes, explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? □ No □ Yes, explain:

At what age did the child: Respond to sound: Follow an object: Hold their head up:

Vocalize: Teeths: Sit alone: Crawl:

Walk: Begin cow's milk: Begin solid food:

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitilization and surgical history, including year:

Please list any major inuries, accidents, falls, and or fractures your child has sustained in their life including year:

Have you chosen to vaccinate your child? □ No □ Yes, on a delayed or selective schedule □ Yes, on schedule

If yes, please list any vaccination reactions:

Has your child received any antibiotics? □ No □ Yes, how many times and list reason

Night terrors or difficulty sleeping? □ No □ Yes, please explain

Behavioral, social, or emotional issues? □ No □ Yes, please explain

How many hours per day does your child typically spend watching TV, computer, tablet, or phone?

How would you describe your child's diet? □ Mostly whole organic foods □ Pretty average
□ High amount of processed foods

## REVIEW OF SYSTEMS

Please write 1 for past and 2 for present for each symptoms you have experienced.

### BALANCED NERVOUS SYSTEM

| | |
|---|---|
| _____ High Energy | _____ No Symptoms |
| _____ Resistance to infections | _____ Positive Mental Attitude |
| _____ Mentally Alert | _____ Excellent health |
| _____ Active | _____ Vibrant |

### UNDER-AROUSED NERVOUS SYSTEM

| | |
|---|---|
| _____ Poor attention | _____ Impulsive |
| _____ Easily distracted | _____ Disorganized |
| _____ Depressed | _____ Lacking motivation |
| _____ Poor concentration | _____ Spaciness |
| _____ Constipation | _____ Low pain threshold |
| _____ Difficulty Waking | _____ Worry |
| _____ Irritable | _____ Low energy |

### OVER-AROUSED NERVOUS SYSTEM

| | |
|---|---|
| _____ Pain | _____ Cold hands |
| _____ Tight muscles | _____ Cold feet |
| _____ Anxiety | _____ Heart palpitations |
| _____ Restless Sleep | _____ Poor expression of emotions |
| _____ Poor immune system | _____ Racing mind |
| _____ High blood pressure | _____ Cramps & menstrual issues |
| _____ Irritable bowel | _____ Indigestion/heartburn |
| _____ Acid reflux | _____ Insomnia |
| _____ Teeth grinding | _____ Diarrhea |
| _____ Allergies & eczema | _____ |

### UNSTABLE NERVOUS SYSTEM

| | |
|---|---|
| _____ Migraines | _____ Headaches |
| _____ Seizures | _____ Autism |
| _____ Sleepwalking | _____ Food Sensitivities |
| _____ Aspergers | _____ ADHD |
| _____ Bed Wetting | _____ Schizophrenia |
| _____ Bi-polar disorders | _____ Panic attacks |
| _____ Mood swings | _____ Sensory Processing Disorder |

### EXHAUSTED NERVOUS SYSTEM

| | |
|---|---|
| _____ Cancer | _____ Diabetes |
| _____ Diabetes | _____ Depression |

I do hereby designate Dr. Michael Vanella and Vanella Chiropractic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above names doctor. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not

_____ _____

Patient Signature Date

## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio- therapy, diagnostic thermography, surface emg, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I agree to.

Patient Signature _____ Date _____

Do not write in this box. For doctor's use only.

**New patient health objectives**

- ☐ **Temporary symptom relief only**
- ☐ **Symptom relief plus correction for prevention of recurrence**
- ☐ **Health Maintenance**
- ☐ **Health Development**

**BALANCED NERVOUS SYSTEM**

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