REFINE
CHIROPRACTIC

Pediatric Health Application

Name_____ Date of Birth ____/____/____ Age_____ Male / Female

Address_____ City_____ State_____ Zip_____

Guardian(s) Name:_____ Relationship:_____

Phone:_____ Email:_____

Preferred Contact: Email / Text Message / Phone Call Weight:_____ Height:_____

Number of Siblings:_____ Names, Ages, and Gender_____

Whom may we thank for referring you?_____

List The Health Concerns That Brought You Into This Office

Health Concern (list by severity)	Rate of Severity (0 = no pain, 10 = unbearable)	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Constant (C) or Intermittent (I)?
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? Yes / No

If Yes: Chiropractor / Medical doctor / Other_____

Who?_____ When?_____ Results?_____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

____ Headaches	____ Ear Infections	____ Sinus Issues	____ Kidney Problems	____ Migraines
____ Hearing Loss	____ Frequent Colds	____ Bladder Problems	____ Sleep Problems	____ Diabetes
____ Jaw/TMJ Pain	____ Ringing in the Ears	____ Thyroid Issues	____ Seizures	____ Tight/Sore Muscles
____ Neck Pain	____ Dizziness	____ Asthma	____ Scoliosis	____ Sports Injury
____ Shoulder Pain	____ Loss of Energy	____ Chest Pain	____ Infertility	____ Sciatica
____ Arm Pain	____ Nervousness	____ Heart Problems	____ Fibromyalgia	____ Joint Pain
____ Upper Back Pain	____ Double/Blurry Vision	____ Nausea	____ Epilepsy/Convulsions	____ GERD/Gastric Reflux
____ Mid Back Pain	____ Anxiety	____ Ulcers	____ Tremors	____ Numb/Tingling in Arms/Hands
____ Lower Back Pain	____ ADD/ADHD	____ Digestive Issues	____ Disc Problems	____ Numb/Tingling in Legs/Feet
____ Hip/Leg Pain	____ Loss of Balance	____ Diarrhea	____ Scoliosis	____ Stomach Problems
____ Knee Pain	____ Depression	____ Constipation	____ Poor Posture	____ Growing pains
____ Foot Pain	____ Allergies	____ Bed Wetting	____ Skin Problems	____ Difficulty Breathing

Other:_____

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Pregnancy Information:

How was your pregnancy?_____

Any pregnancy complications?_____

Did you take any medication during your pregnancy?_____

Other information:_____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section

Induced? Yes/No Explain:_____

Medications during delivery?_____

Other information:_____

Post Birth Information:

Birth Weight:_____ Birth Length:_____

Breast Fed: Yes/No How long?_____ Formula Fed: Yes/No How Long?_____

Introduced Solid Foods at _____ Months

Food Allergies or Intolerances:_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____ Total Lifetime_____

Present prescription drugs/ dosage?_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)_____

List all surgical operations & years:_____

Has your child ever been knocked unconscious? Yes / No Fractured A Bone? Yes / No

If yes to either of the above, please describe:_____

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Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. What is your typical or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What percentage of your awake hours is your pain at its best? _____ %

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What percentage of your awake hours is your pain at its worst? _____ %

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Holding Head Up O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Tummy Time O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Nursing O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Sitting Up O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Crawling O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Standing Alone O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Walking Alone O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Other:_____ O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Other:_____ O No Effect O Painful (can do) O Painful (limits) O Unable to Perform

Functional Goals

ACTIVITY	CURRENT ACTIVITY LEVEL	GOAL ACTIVITY LEVEL
Example: Tummy Time	*Less than 2 minutes*	*5 minutes*

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For A Minor/Child, Please Fill Out And Sign Below

Written Consent For A Child

Name of practice member who is a minor/child:_____

I authorize Dr. Albir Rifati, D.C. and any and all Refine Chiropractic staff to perform diagnostic procedures, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Refine Chiropractic.

Guardian Signature:_____ Date:_____

Relationship To Minor/Child:_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature:_____ Date:_____