Chiropractic First
Pediatric History Form

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name _____

Address _____ City _____

State _____ Zip _____ Home Phone _____

Birth Date ____/____ /____ Work Phone _____

Sex____ Weight____ Height____ Referred By _____

Names of Parents / Guardians _____

_____

Purpose For Contacting Us

Other Doctors Seen for this Condition ____N ____Y Doctor's Names and Prior Treatments_____

_____

Other Health Problems _____

_____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months

Ear Infections ☐	Scoliosis ☐	Seizures ☐	Chronic Colds ☐	Headaches ☐
Asthma/Allergies ☐	Digestive Problems ☐	ADHD ☐	Recurring Fevers ☐	Growing/Back Pain ☐
Colic ☐	Bed Wetting ☐	Car Accident ☐	Temper Tantrums ☐	Other _____

Family History

Previous Chiropractor _____

Date of Last Visit ____/____/____ Reason_____

Are You Satisfied with the Care Your Child has Received There? ____N ____Y

Number of Doses of Antibiotics Your Child has taken ____

During the past six months____ Total During His/Her Lifetime____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Pat Six Months ____ Total During his/Her Lifetime ____ List _____

_____

Vaccination History _____

Prenatal History

Name of Obstetrician / Midwife _____

Complications During Pregnancy ____ N ____Y List

Ultrasounds During Pregnancy ____ N ____Y Number

Medications During Pregnancy / Delivery ____N ____Y List

Cigarette / Alcohol Use During Pregnancy ____ N ____Y

Location of Birth ____Hospital ____Birthing Center ____Home

Birth Intervention ____Forceps ____Vacuum Extraction ____ Ceasarian Section

____Emergency or Planned

Chiropractic First

Pediatric History Form

contd.

Prenatal History - contd.

Complications During Delivery ____N ____Y List _____

Genetic Disorders or Disabilities ____ N ____ Y List _____

Birth Weight ____ Birth Length____ APGAR Scores____

Feeding History

Breast Fed____ N ____Y How Long____ Formula Fed N____ Y____ How Long____ Type_____

Introduced to Solids at____Months, Cow's Milk at ____ Months

Food / Juice Allergies or Intolerance ____N____Y List _____

Development History

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

Respond to Sound____ Cross Crawl____

Respond to Visual Stimuli ____ Stand Alone____

Hold Head Up____ Walk Alone____

Sit Up____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ____N____Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ____N ____Y List_____

Has Your Child Ever Been Involved in a Car Accident? ____N ____Y List

Has Your Child Been Seen on an Emergency Basis? ____N ____Y List

Other Traumas Not Described Above? ____N ____Y List

Prior Surgery ____N ____Y List

Menarche ____N ____Y Age

Childhood Diseases

Chicken Pox	N / Y	Age____	Mumps	N / Y	Age____
Rubella	N / Y	Age____	Whooping Cough	N / Y	Age____
Rubeola	N / Y	Age____	Other	N / Y	Age ____

Chiropractic First

Dr. Elizabeth Erkenswick Welcomes You To Our Office

Prepared For: _____

Let me extend a warm and personal welcome to you on behalf of the staff and myself. We want to provide you with the finest health care and we'll offer you many informative and entertaining educational opportunities.

First, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health objectives. Secondly, this information will be useful in making decisions about your health for the rest of your life. To begin this process, here are a few important terms and procedures as you begin care:

On your first visit we will gather information about you through our examinations and consultations. There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

We will be giving you information and clinical data in the form of literature, personal and media presentations. these are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Just as we need to know about you, you should know about us. Chiropractic education currently consists of three years (90 hours) of pre-Chiropractic college education in the biological sciences, followed by another three years and four months (10 trimesters) of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

We have minimized paper work in our office. However, there are clinical forms that must be filled out accurately for your health, legal and profession reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below is a space for your name and four descriptions of prevalent health attitudes. Please mark the one that most closely reflects your personal values.

Name: _____

☐ Treatment Only. I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

☐ Prevention. In addition to symptomatic treatment, I consult specialist occasionally to prevent problems from recurring.

☐ Maintaining Health. I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.

☐ Family Health. I rake an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health

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Patients Advisory And Permissions - To Be Read And Signed By All Patients

We do not accept insurance plans. Rather, our assistance to you will be in the form of providing itemized receipts for your Chiropractic care which you may then submit to your insurance company. **Your insurance reimbursement will depend upon the nature of your policy.** By choosing care at Chiropractic First, you accept responsibility for payment of services as services are rendered.

If the patient is a minor, I as parent or guardian consent to have Dr. Liz Erkenswick render care to _____

I give authorization to disclose my records if required by my insurance provider or another healthcare provider.

I have read and understood the above information. I agree to pay as services are provided and I accept responsibility for pursuing insurance reimbursement.

SIGNED_____

DATE_____

Chiropractic First, S.C.

Network Spinal Analysis™(NSA) Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides *Network Spinal Analysis* (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the *Council on Chiropractic Practice Guidelines* and the *Canon of Ethics of the Association for Network Care*, and my doctor(s) has been trained in traditional chiropractic care and certified in the procedures of *Network Spinal Analysis Care*.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.***

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, reassessment will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

NSA is advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, the redistribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/.spinal care or advice that is consistent with my individual needs.

Network Spinal Analysis™ (NSA) Consent Form
contd.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I ***have read, or have had read to me, the CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS™ (NSA) CARE and understand that the care in this office is different from what many consumers may expect from chiropractors prac-***

_____
Printed Name of Practice Member

_____ _____
Signature of Practice Member DATE

_____
Printed Name of Witness

_____ _____
Signature of Witness DATE