

Pediatric Information

THE ROCK HEALTH & WELLNESS CENTERS
Date _____

Personal Information	Parent's Information
Name _____	Mom's Name _____
Address _____	Dad's Name _____
City _____	Home Phone _____
State _____ Zip _____	Cell Phone _____
Date of Birth ____ / ____ / ____ Age ____ Sex ____	E-mail _____
Referred by _____	

History
Purpose for Contacting Us:
Other Doctors Seen for this Condition:
Prior Treatments:
Other Health Concerns:
Prior Surgeries:

Drug History
Current Medications:
Number of Antibiotics: (Life) _____ (Last 6 Months) _____
Vaccination History:

Doctor Information
Previous Chiropractor: _____ Date of Last Visit _____
Name of Pediatrician: _____ Date of Last Visit _____
Name of Obstetrician: _____

Health History (Mark all that apply)
Complications During Pregnancy: (No) _____ (Yes) _____ Explain: _____
Type of Birth: (Normal Vaginal) _____ (C-Section) _____ (Epidural) _____ (Forceps) _____ (Suction) _____ (Breech) _____
Feeding History: (Breast Fed) Y / N _____ How Long? _____ (Formula) Y / N _____ How Long? _____

Terms of Acceptance

When a patient seeks Chiropractic Wellness care and we accept a patient for such care, it is essential for us both to be working toward the same objective. Chiropractic Wellness has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. The foundation of our Chiropractic Wellness method of correction is by specific adjustment of the spine.

Health: A state of consistent homeostatic cell function.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our methods are specific adjusting to correct vertebral subluxation, nutritional recommendations and mental/emotional strategies.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept Chiropractic Wellness care on this basis.

Signed _____ Date _____

Consent to Evaluate and Adjust a Minor

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a Chiropractic Wellness examination, which may include x-rays if necessary, and a Chiropractic Adjustment.

Signed _____ Date _____

