The Life Studio

3020 Bridgeway, Suite 103
Sausalito, CA 94965
415.887.9689
www.thelifestudiosausalito.com

PEDIATRIC PRE-EXAM INFORMATION

(Click on Insert and Underline when on-line to fill in the spaces.)

Patient Name: _____ Date of birth:_____

Telephone: _____ Alternative Number:

_____

Street Address: _____ City: _____State: _____ Zip:

_____

Email Address: _____

Father's Name:

_____

Mother's Name:

_____

Siblings:

Name: _____ Age: _____

Gender:_____

Name: _____ Age: _____

Gender:_____

Name: _____ Age: _____

Gender:_____

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Name: _____ Age: _____

Gender:_____

Name: _____ Age: _____

Gender:_____

Emergency Contact: _____ Telephone:

_____

Referred by:

_____

Purpose of your visit:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Please indicate if any blood relatives to the child have had any of the following by using the notations:

M = Mother MGM = Maternal Grandmother PGM = Paternal Grandmother

F = Father MGF = Maternal Grandfather PGF = Paternal Grandfather

S = Sibling

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____ Allergy, Asthma or Eczema

____ Cancer

____ Diabetes or Low Blood Sugar

____ Heart Trouble

____ High Blood Pressure/Stroke

____ Kidney Disease

____ Liver Disease

____ Developmental Disability

____ Mental Illness

____ Scoliosis

____ Ulcer

____ Seizure Disorder

____ Vaccine Reaction

____ Other: _____

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PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

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- ○ Prenatal Classes
- ○ Premature Contractions
- ○ Complications
- ○ Back Pain
- ○ Bleeding
- ○ Other Pain
- ○ Hospitalization
- ○ Smoking
- ○ Alcohol
- ○ Recreational Drugs
- ○ Excessive Weight Loss
- ○ Excessive Weight Gain
- ○ Medications
- ○ Toxic Exposures
- ○ Caffeine: Cola
- ○ Caffeine: Coffee
- ○ Caffeine: Tea
- ○ Caffeine: Chocolate
- ○ Caffeine: Other
- ○ Immunizations/Flu Shot
- ○ Allergic Reactions
- ○ Mental Trauma
- ○ Vitamins/Minerals
- ○ Chiropractic Care
- ○ Any Diagnosed Illnesses
- ○ Attitude – Mostly Happy
- ○ Attitude – Mostly Depressed
- ○ Physical Injury

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LABOR AND DELIVERY

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- ○ Home Birth
- ○ Hospital Birth
- ○ Induction
- ○ Caesarean
- ○ Complications
- ○ Fetal Monitor Used
- ○ Premature Delivery
- ○ Medications
- ○ Vacuum Extraction
- ○ Forceps
- ○ Other: _____

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Please check any item(s) that applied to the patient at birth:

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- ○ Difficulty Breathing
- ○ Choking
- ○ Crying
- ○ Sleeping Excessively
- ○ Difficulty Waking/Lethargic
- ○ Jaundice
- ○ Coloring
- ○ Difficulty latching on
- ○ Difficulty breastfeeding
- ○ Medications
- ○ Surgery
- ○ Circumcision
- ○ Formula Feeding
- ○ Vitamin K
- ○ Erythromycin
- ○ Other: _____

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BIRTH INFORMATION

Length of Pregnancy: _____

Birth weight: _____ Birth length:_____ Head Circumference:

_____

APGAR Score at 1 minute: _____ At 5 minutes: _____

NUTRITION

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○ Breast Milk

○ Commercial Formula

○ Cow's Milk

○ Goat's Milk

○ Other Milk: _____

○ Juice: Fruit

○ Juice Vegetable

○ Solid Foods

○ Vegetarian Diet

○ Organic Meats

○ Vitamins

○ Sweets/Candy

○ Medications

○ Other: _____

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VACCINATIONS/IMMUNIZATIONS

Please list if the patient has had any vaccinations (immunizations):

Date	Type	Response

Has the patient traveled abroad? Where?

_____

ILLNESSES

Please list any illnesses or previously diagnosed conditions:

_____

_____

_____

_____

_____

Please list any accidents or injuries that have occurred.

_____

_____

_____

_____

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GENERAL SYSTEM REVIEW

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- ○ Had any allergies, eczema, hay fever, hives, asthma or drug reactions?
- ○ Been unconscious or had a convulsion?
- ○ Had problems with the eyes, including vision?
- ○ Been cyanotic (turned blue)?
- ○ Had recurring problems with vomiting, diarrhea, constipation or stomach pain?
- ○ Had problems passing stools?
- ○ Had unusual stools in appearance or smell?
- ○ Had problems passing urine?
- ○ Had unusual urine in appearance or smell?
- ○ Complain of any extremity or back pain?
- ○ Do you notice a limp or unusual gait pattern?
- ○ Tolerated exercise?
- ○ Had any other problems?

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Please add any information you think will be helpful.

_____

_____

_____

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_____

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_____

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Informed Consent

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Parent/Guardian of _____
do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Treatment Results

I understand that there are beneficial effects associated with treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

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I agree to the performance of these procedures by my doctor.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Nontreatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of patient

_____ Signature of Parent/Guardian

_____ Signature of witness

_____ Date and time