



**TEAM MEMBERS ONLY**  
Today's Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
PM File Number: \_\_\_\_\_

## Pediatric Practice Member Application

### PATIENT DEMOGRAPHICS

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mother's Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Father's Phone: \_\_\_\_\_

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Last Visit \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Reason for visit: \_\_\_\_\_

**Whom may we thank for referring your child to this office?** \_\_\_\_\_

### HISTORY OF CURRENT HEALTH CONCERNS

**Purpose of this visit:** \_\_\_\_ Wellness Check-up \_\_\_\_ Injury or Accident \_\_\_\_ Other

Please explain: \_\_\_\_\_

*If your child is experiencing **Pain/Discomfort**, please identify where and for how long:*

1. **When did the** Problem first begin? Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_  Unknown  Gradual  Sudden
2. **Ever had** this problem **before**?  No  Yes If yes, when? \_\_\_\_\_
3. Any **bowel or bladder** problems since this problem began?  No  Yes If yes, describe:  
\_\_\_\_\_
4. Have you seen any **other doctors** for this problem?  No  Yes If yes, who?  Chiropractor  MD  Other \_\_\_\_\_  
When? \_\_\_\_\_ Results? \_\_\_\_\_
5. How long ago? \_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years
6. What were the results of past treatment? \_\_\_\_\_
7. How is this problem **NOW?**:  Rapidly Improving  Slowly Improving  About the Same  Gradually Worsening  On & Off
8. Please list any **medication taken** for this problem: \_\_\_\_\_
9. Has your child ever sustained an injury playing organized sports?  No  Yes If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
10. Has your child ever sustained an injury in an auto accident?  No  Yes If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

**HAS YOUR CHILD EVER SUFFERED FROM:** *Check all that apply*

**FALL FROM:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Digestive Disorders  | <input type="checkbox"/> Orthopedic Problems  | <input type="checkbox"/> Baby Walker            |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Poor Appetite        | <input type="checkbox"/> Bed/Couch/Furniture    |
| <input type="checkbox"/> Arm/Hand Problems   | <input type="checkbox"/> Ear Infections/Aches | <input type="checkbox"/> Poor Posture         | <input type="checkbox"/> Bicycle                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Reflux               | <input type="checkbox"/> Changing Table         |
| <input type="checkbox"/> Back Aches          | <input type="checkbox"/> Growing Pains        | <input type="checkbox"/> Ruptures/Hernia      | <input type="checkbox"/> Crib                   |
| <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> High Chair             |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Monkey Bars/Playground |
| <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> Skateboard/Skates      |
| <input type="checkbox"/> Colds/Flu           | <input type="checkbox"/> Joint Problems       | <input type="checkbox"/> Sleeping Problems    | <input type="checkbox"/> Slide                  |
| <input type="checkbox"/> Colic               | <input type="checkbox"/> Leg/Foot Problems    | <input type="checkbox"/> Stomach Aches        | <input type="checkbox"/> Stairs                 |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Muscle Pain          | <input type="checkbox"/> Walking Trouble      | <input type="checkbox"/> Swing                  |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Neck Problems        |   |   |
- Allergies to: \_\_\_\_\_
- Other: \_\_\_\_\_

**PREGNANCY INFORMATION**

How was your pregnancy? \_\_\_\_\_

Any pregnancy complications? \_\_\_\_\_

Did you take any medication during your pregnancy? \_\_\_\_\_

Other information: \_\_\_\_\_

**DELIVERY INFORMATION**

Birth Intervention:            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: \_\_\_\_\_

## QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

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.

**EXAMPLE:** No pain \_\_\_\_\_ Back pain Headaches \_\_\_\_\_ Worst possible pain  
 0 1 2 **3** 4 5 6 7 **8** 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake 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?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake 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:

ACTIVITIES:	EFFECT:			
Holding Head Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Tummy Time	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Nursing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Crawling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing with Friends	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

LIST ANY OTHER RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

**CHILD/MINOR INFORMED CONSENT FOR CHIROPRACTIC CARE**

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

Name of practice member who is a minor/child: \_\_\_\_\_

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

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship to Child/Minor: \_\_\_\_\_

**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 (HIPPA). 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 physician’s 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.

\_\_\_\_\_  
**Practice Member Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

**X-RAY AUTHORIZATION**

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Invictus Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

*By signing below you are agreeing to the above terms and conditions.*

\_\_\_\_\_  
**Practice Member Printed Name**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Practice Member Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**