Dr. Jonathan T. Currier
4956 Benchmark Centre Dr. Suite B
Swansea,IL 62226
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Pediatric
Infants & Toddlers

Patient Information

Child's Name: _____ Date:_____/_____/_____

Parent's/Guardian's Names: _____

Home Address: _____City_____ State _____ Zip_____

Home Phone: _____-_____-_____ Parent's Cell: _____-_____-_____

Parent's Work: _____-_____-_____

Parent's Email: _____

May we send you helpful health updates? (Sent out every 2 weeks; Your Email not shared) (Circle One) Yes No

How did you hear about us? _____

Height (of child): _____ Weight (of child): _____ Birth Date: _____/_____/_____

Sex: (Circle One) M F

Siblings and Ages: _____ _____ _____

Previous Chiropractic Care? (Circle One) Yes No

Emergency Contact

Name: _____ Relationship to Child: _____

Phone Number: _____-_____-_____ Alternate Phone Number: _____-_____-_____

Family Doctor

Name: _____ Clinic Name: _____

Date and Reason of Last Visit: _____

May we communicate with you family doctor regarding your child's care if necessary? (Circle One) Yes No

Other Health Care Professionals?
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc.)

_____

Why have you decided to have your child evaluated by a Chiropractor?

- ☐ Wellness care (improving child's immune function).
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ He/she is continuing ongoing care from another chiropractor.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/she has a specific condition and I've learned that chiropractic may be able to help.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, some starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system in a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches / Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

Do you have a specific concern that bring you in?

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse, or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint?

☐ No if yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? .(Circle One) No Yes_____

Has your child ever experienced this complaint before? ..... No Yes_____

Did they receive any treatment at the time? ..... No Yes_____

Has your child had x-rays in relation to the current complaint? ..... No Yes_____

Prenatal Profile

☐ Adopted ☐ Prenatal History Unknown ☐ Birth History Unknown

Complications during pregnancy: (Circle One) No Yes (brief description): _____

Ultrasounds during pregnancy: (Circle One) No Yes (how many): _____

Medications during pregnancy: (Circle One) No Yes _____How often? _____

Exposure to alcohol, cigarettes or seconds hand smoke during pregnancy: (Circle One) No Yes: _____

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other_____

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other_____

Medications during labor / delivery (including IV antibiotics) : (Circle One) No Yes _____

Was Pitocin used to induce / speed up labor? (Circle One) No Yes

Were your membranes ruptured by a medical professional? (Circle One) No Yes

Was your child at anytime during your pregnancy in an intra-uterine constraining position? (Circle One) No Yes Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? _____ If it was a C-section, was it planned or emergency?_____

Were any of the following interventions used during delivery? ☐ Forceps ☐ Vacuum Extraction ☐ Other

Were there any complications during delivery? ☐ Yes ☐ No

If yes, please specify:_____

How long was the labor from the first regular contractions to the birth? _____Hours

How long was the second stage (the pushing phase) of the labor? _____Hours

Was the baby born with any purple markings / bruising on their face or head? (Circle One) No Yes

Any concerns about misshapen head at birth? (Circle One) No Yes

Post Natal History

How many weeks gestation was the baby at birth? _____w _____d / Birth Weight:_____lbs_____oz / Birth Length _____in

If known, APGAR scores at: 1 minute_____/10 5 minutes_____/10

Was the baby ever administered to Neonatal Intensive Care? (Circle One) Yes No

If yes, for how long and why?_____

Was any medication given to the baby at birth? (Circle One) Yes No Unsure

If yes, what medication and why?_____

Child Health History *(Answer only those which are applicable)*

How many hours does your baby sleep between feedings? _____ Day _____ Night

Does your child have a preferred sleeping position? (Circle One) No Yes _____

Does your child have any feeding difficulties? (Circle One) No Yes _____

Is your child currently being breast fed? ☐ Yes, exclusively ☐ Formula supplemented ☐ No

If no, how long was the baby breast fed? _____ weeks/months

Does your child have a one-sided breast preference? (Circle One) No Yes If yes, Prefer Left or Right? _____

Does your child frequently spit up after feeding? (Circle One) No Yes

Does your child cry often? (Circle One) No Yes If yes, approximately how many hours of the day? _____

Does your child pass a lot of intestinal gas? (Circle One) No Yes

Child Health History (Cont.)

Does your child frequently arch his/her head and neck backwards? (Circle One) No Yes
Has your child shown any sensitivities to foods either in your diet or their own? (Circle One) No Yes _____
Is your child exposed to cow's milk/dairy? ☐ No ☐ Yes, formula ☐ Yes, directly ☐ Yes, I drink it and breastfeed.

Developmental History

Has your child ever fallen from any high places? . (Circle One) . . . . . No Yes _____
Has your child ever been involved in a motor vehicle accident or near miss? . . . No Yes _____
Has your child been seen on an emergency basis? . . . . . No Yes _____
Has your child broken any bones? . . . . . No Yes _____
Has your child had any previous hospitalization? . . . . . No Yes _____
Has your child had any previous surgeries? . . . . . No Yes _____

Chemical Stressors

Have you chosen to vaccinate your child? (Circle One) No Yes, on a delayed or selective schedule Yes, on schedule
Reason for vaccination: ☐ Informed decision ☐ Didn't know I had a choice ☐ It was recommended
Reaction(s) to vaccination: ☐ Fever ☐ Welt at injection site ☐ Rash ☐ Diarrhea ☐ Fatigue ☐ Prolonged Cry
☐ Seizures ☐ Developmental Regression ☐ Other _____
Does your child receive annual flu shots? (Circle One) No Yes, (informed decision) Yes, (recommended by MD)
Has your child been exposed to antibiotics? (Circle One) No Yes
If yes, how many doses in past 6 months? _____ Reason _____
Were probiotics used at the same time as antibiotics? (Circle One) No Yes
Has your child been exposed to medications, including OTC: (Circle One) No Yes
If yes, which ones? _____
If yes, how many does in past 6 months? _____ Reason _____
How many glasses or water / day does your child have? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of cow's milk, juice and soda / day does your child have? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
Does your child eat gluten? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat dairy? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? ☐ Yes ☐ No ☐ Trying to eliminate
Does your child eat boxed / frozen foods? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet
Do you choose organic foods? ☐ No ☐ Yes If yes, which: ☐ Veggies ☐ Fruits ☐ Meats ☐ Grains ☐ All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐ No ☐ Yes
Does your child follow any other dietary restrictions? ☐ No ☐ Yes _____
Any food / drink allergies, sensitivities, intolerances? ☐ No ☐ Yes _____
Is your child exposed to second hand smoke? ☐ No ☐ Yes _____
Does your child take a probiotic daily? ☐ No ☐ Yes _____ CFU's/day
Does your child take vitamin D3 daily? ☐ No ☐ Yes _____ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes _____ mg/day ☐ Capsule ☐ Liquid
Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: (Circle One) Yes No _____

Emotionally: (Circle One) Yes No _____

Physically: (Circle One) Yes No _____

What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I _____ being the parent or legal guardian of _____,
Hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting commencement of treatment, if appropriate.

_____ _____

Consenting Adult's Signature Date

FAMILY HEALTH HISTORY

Many health problems are hereditary and may be handed down generation after generation.

Patient: _____

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( ) Age( )		SISTER(S) Age( ) Age( )		CHILDREN Age( ) Age( ) Age( )		
Alzheimer's										
Epilepsy or Seizures										
Parkinson's Disease										
Stroke										
Headaches/Migraines										
Numb hands/feet										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Heart Arrhythmia										
Atrial/Ventricular Fibrillation										
Atherosclerosis										
Aneurysm										
Fainting/light-headed										
Back Pain										
Neck Pain										
Disc Bulge/Herniation										
Pinched Nerve										
Arthritis										
Scoliosis										
Asthma										
ADHD										
Allergies (food)										
Allergies (seasonal)										
Sinus infections										
Heart Burn / reflux										
Constipation										
Miscarriage										
Cancer/Tumor										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

LIFE SPINE
HEALTH ENHANCEMENT CENTER

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are many different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors

and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Dr. Jonathan T. Currier of LifeSpine Health Enhancement Center TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____, 20___

_____ _____

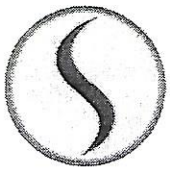
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ **DOB:** _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____



DR. J. CURRIER D.C., M.S.
4956 Benchmark Centre Dr. Suite B
Swansea, IL 62226

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at the office of Dr. J. Currier D.C., M.S. we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to: Dr. J. Currier, 4956 Benchmark Centre Dr. Suite B Swansea, IL 62226. If you would like further information about our privacy policies and practices, please contact: Dr. J. Currier at 618-622-9770.

This notice is effective as of _____. This notice, and any alterations or amendment made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____	_____
Personal Representative (Printed)	Personal Representative Signature	Date

_____

Description of the authority to act on behalf of the patient.