EnVitality Wellness Center, LLC
Dr. Jacqueline L. Berens, DC
www.EnVitalityWellness.com

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Pediatric Information

Date: _____ **How were you referred to the office?** _____

Name of Child: _____

Name of Parent(s)/Guardian(s):_____

Date of Birth: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____**Zip:**_____

Home Phone: (____)_____ **Cell Phone:** (____)_____

Names & Ages of Siblings (Optional):

_____

Name of Pediatrician: _____ **Office Phone**:(____)_____

Date of last visit: _____ **Reason for last visit:** _____

May we update your pediatrician regarding your care at this office if needed? ☐ **Yes** ☐ **No**

Health History

What is your child's EnVitality Rating? *(How healthy do you feel your child is when compared to others their age?)*
Please circle: 0 Not Very Healthy, 10 Very Healthy

0 1 2 3 4 5 6 7 8 9 10
☐☐☐☐☐☐☐☐☐☐☐

What brings your child to the office today?

_____
_____
_____
_____
_____
_____

P: 303-668-2103

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Medical History

Please check any current or past problems your child has experienced below:

- ☐ Dizziness
- ☐ ADHD
- ☐ ADD
- ☐ Heart Condition
- ☐ Chronic Earaches
- ☐ Diabetes
- ☐ Genetic Disorder
- ☐ Hypertension
- ☐ Fever/Chills
- ☐ Autism/ASD
- ☐ Blood Disorders
- ☐ Rashes
- ☐ Unusual Moles
- ☐ Developmental Delays

☐ Other: _____

- ☐ Frequently Getting Sick
- ☐ Arthritis
- ☐ Headaches
- ☐ Asthma
- ☐ Allergies
- ☐ Runny Nose
- ☐ Ichy Eyes
- ☐ Coughing/Wheezing
- ☐ Sinus Trouble
- ☐ Asymmetric Crawling
- ☐ Learning Difficulties
- ☐ Poor Appetite
- ☐ Hyperactivity
- ☐ Motor/Coordination Delays

- ☐ Eye Problems
- ☐ Chest Pain
- ☐ Constipation
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Poor Memory
- ☐ Insomnia
- ☐ Nightmares
- ☐ Bed Wetting
- ☐ Convulsions
- ☐ Seizures
- ☐ Stomach/Digestive Problems

- ☐ Muscle Pain
- ☐ Fainting
- ☐ Broken Bone(s)
- ☐ Sprains/Strains
- ☐ Hernias
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Arm/Leg Pain
- ☐ Foot Pain
- ☐ Growing Pains
- ☐ Joint Pain
- ☐ Scoliosis
- ☐ Attention Problems

FOR GIRLS ONLY:
Has your period started: ☐ Yes ☐ No
Age:____

Has your child been injured participating in sports (soccer, football, volleyball, martial arts, etc…) ☐ **Yes** ☐ **No**
If yes please describe: _____

Has your child ever had a concussion or fallen head first from a changing table, bed, tree, etc. ☐ **Yes** ☐ **No**

Other traumas not described above? ☐ **Yes** ☐ **No** **If Yes, Type & Date:**_____

Prior surgery: ☐ **Yes** ☐ **No** **If Yes, Type and Date:**_____

Adverse Reactions to Any Vaccine(s)? ☐ **Yes** ☐ **No** **If yes, please list:** _____

Food/Juice Allergies or Intolerances? ☐**Yes** ☐ **No** **If yes, please list:** _____

Is your child on any medications? ☐**Yes** ☐ **No** **If yes, please list:** _____

Is your child taking any supplements? ☐**Yes** ☐ **No** **If yes, please list:** _____

Any other concerns about your child? ☐**Yes** ☐ **No** **If yes, please list:** _____

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Developmental History

Sleep: _____ hrs per night **Naps:** (number & lengths) _____ **Problems sleeping:** ☐ Yes ☐ No

Did your child meet the following milestones on time:
Sit: ☐ Yes ☐ No **Crawl:** ☐ Yes ☐ No **Stand:** ☐ Yes ☐ No **Walk:** ☐ Yes ☐ No **Say words:** ☐ Yes ☐ No

(For Infants Only) Prenatal and Feeding History

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Stepchild ☐ Adopted

Medications during pregnancy/delivery: ☐ **Yes** ☐ **No** **If yes, please describe:**_____

Birth type and intervention(s): ☐ **Vaginal** ☐ **Caesarian** ☐ **Forceps** ☐ **Vacuum** ☐ **Epidural**

Breast Fed: ☐ **Yes** ☐ **No** **If yes, how long?**_____ months

Formula fed: ☐ **Yes** ☐ **No** **If yes, how long?**_____ months **Type of Formula**:_____

Introduced to solids at _____ months **Cow's milk:** ☐ **Yes** ☐ **No** **If yes, at:** ____months

Consent For Care

TERMS OF ACCEPTANCE: I, the parent or guardian of my child, have been advised about chiropractic care, and like all types of health care, chiropractic can hold certain risks. While the risks are most often very minimal, in rare isolated cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

When a patient seeks chiropractic health care, deep tissue laser therapy, and/or any other service provided in our office and we accept a patient for such care, it is absolutely essential for both Patient and Doctor to be working towards the same health objective. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at the EnVitality Wellness Center, LLC, have been explained to me to my satisfaction, all my questions have been answered, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to treatment of my child by any means, method, and/or techniques the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of his/her care, and agree to hold them harmless of consequences thereof.

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AUTHORIZATION AND RELEASE: I, the parent or guardian of my child, understand and agree to allow EnVitality Wellness Center, LLC, to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand and agree that I am responsible for all costs of care at the time of service, unless otherwise arranged. My child's Patient Health Information and my rights concerning these records will be protected according to HIPAA.

FEMALES ONLY REGARDING X-RAY/IMAGING STUDIES:
Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my daughter's last menstrual cycle was on _____/_____/_____ (Date)

☐ I have been provided a full explanation of when my daughter is most likely to become pregnant, and to the best of my knowledge, my daughter is not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent for my daughter to have the diagnostic x-ray examination if the doctor has deemed it necessary.

CONSENT TO TREAT A MINOR: After careful consideration, I authorize treatment by any means, method, and/or techniques the doctor deems necessary to treat _____(child's name). I certify that I have the authority and responsibility to authorize treatment for this child.

I authorize EnVitality Wellness Center, LLC and the doctor and/or staff to treat the above listed child in the absence of my presence under normal office visit circumstances. ☐ **Yes** ☐ **No** **Initial:**_____

Parent or Legal Guardian's Signature: _____ **Date:** _____

Office Use Only

Dr. Notes:_____

_____

_____

_____

Doctor's Signature: _____ **Date:** _____

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