

VANELLA CHIROPRACTIC

"Helping families get well and stay well for a lifetime."

Child's Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
DOB:	AGE:	Height:	Weight:
Parent/Guardian's Name:			
Address			Zip code:
Email:		Cell Phone:	
How did you hear about us?			
Who is your primary care physician?			
Are you also receiving care from any other health professionals? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please name them and speciality: _____			
Please list any drugs/medications/vitamins/herbs/other your child is taking:			
CURRENT HEALTH CONDITIONS			
What health condition(s) bring your child to be evaluated by a chiropractor?			
Has your child received care for this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: _____			
When did the condition(s) first begin?			
How did the problem start? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Post injury			
Is this condition <input type="checkbox"/> Getting worse <input type="checkbox"/> Improving <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Unsure			
What makes the problem better?			
What makes the problem worse?			
HEALTH GOALS FOR YOUR CHILD			
What are your top 3 health goals for your child:		What would you like to gain from chiropractic care?	
1		<input type="checkbox"/> Resolve existing condition	
2		<input type="checkbox"/> Overall wellness	
3		<input type="checkbox"/> Both	
Have you ever visited a chiropractor? <input type="checkbox"/> No <input type="checkbox"/> Yes, what is their name?			
What is their specialty? <input type="checkbox"/> Pain relief <input type="checkbox"/> Physical therapy & rehab <input type="checkbox"/> Nutritional <input type="checkbox"/> Subluxation <input type="checkbox"/> Other			
PREGNANCY & FERTILITY HISTORY (please tell us about your pregnancy)			
Any fertility issues? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:			
Did mother smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes, how many per week?			
Did mother drink? <input type="checkbox"/> No <input type="checkbox"/> Yes, how many per week?			
Did mother exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:			
Was mother ill? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:			
Any ultrasounds? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:			
Please explain any notable episodes of mental or physical stress during your pregnancy:			
Please explain any other concerns or notable remarks about your child's conception or pregnancy?			

LABOR & DELIVERY HISTORYChild's birth was Natural vaginal birth Scheduled C-section Emergency C-section

At how many weeks was your child born? _____ Doctor/Obstetrician's name: _____

Child's birth was At home At a birthing center At a hospital Other _____

Please check any interventions or complications:

 Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps Other _____Please describe any other concerns or notable remarks about your child's labor and/or delivery?

Child's birth weight: _____

Child's birth height: _____

APGAR score at birth: _____

APGAR score after 5 minutes: _____

GROWTH & DEVELOPMENT HISTORYIs/was your child breastfed? No Yes, how long? _____Difficult with breastfeeding? No Yes _____Did they ever use formula? No Yes, at what age? _____

If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation? No Yes, explain: _____Did/does your child frequently arch their neck/back, feel stiff, or bang their head? No Yes, explain: _____

At what age did the child: Respond to sound: _____

Follow an object: _____

Hold their head up: _____

Vocalize: _____

Teeths: _____

Sit alone: _____

Crawl: _____

Walk: _____

Begin cow's milk: _____

Begin solid food: _____

Please list any food intolerance or allergies, and when they began: _____
_____Please list your child's hospitalization and surgical history, including year: _____
_____Please list any major injuries, accidents, falls, and or fractures your child has sustained in their life including year: _____
_____Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on scheduleIf yes, please list any vaccination reactions: _____
_____Has your child received any antibiotics? No Yes, how many times and list reason _____Night terrors or difficulty sleeping? No Yes, please explain _____Behavioral, social, or emotional issues? No Yes, please explain _____

How many hours per day does your child typically spend watching TV, computer, tablet, or phone? _____

How would you describe your child's diet? Mostly whole organic foods Pretty average High amount of processed foods

I do hereby designate Dr. Michael Vanella and Vanella Chiropractic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above names doctor. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered

Parent/Guardian Signature_____
Date

Vanella Chiropractic 4661 Haygood Rd. #110 Virginia Beach, VA 23455 757-270-1333

TURN PAGE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio-therapy, diagnostic thermography, surface emg, and any supportive therapies on my child (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I

Patient Signature

Date

Do not write in this box. For doctor's use only.

New patient health objectives

- Temporary symptom relief only
- Health Maintenance

- Symptom relief plus correction for prevention of recurrence
- Health Development

