COAST FAMILY CHIROPRACTIC

Lifetime Wellness For All Ages

Pediatric Consultation

Name: _____ Date: _____

The vast majority of our patients have experienced literally dozens of impacts that could cause subluxation. What I want to do now is discover several of yours.

What was your child's birth like?_____
How long was labor_____ How long did you push_____
Were you induced? Yes No Nerve block? Yes No C-section? Yes No

Was there any pulling on the head? Yes No Forceps or Vacuum Extraction used? Yes No

47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.

When was your child's most recent fall? _____
Was any care given? _____ Was s/he checked by a chiropractor? Yes No

And the fall before that? _____ Any care given?_____

What sports or recreational activities does s/he do?_____

When was your child's most recent stress, strain, or injury while doing these activities?_____

Care given? _____

Has your child been involved in a motor vehicle accident as a passenger? Yes No
If yes, please describe _____
Any treatment received? _____ Chiropractic? _____

These are all important. Thank you for explaining your son/daughter's history of accidents and traumas. This will help the doctor better understand the case. What I want to do now is ask a few questions about your child's current health concerns.

Does s/he have any health concerns at present? Yes No
If Yes, please describe and for how long? _____

Any medications? _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Coast Family Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interests.

The Probability of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one in a million chance of such an outcome. Since even that risk should be avoided, we look at risk factors and will perform tests to identify if you may be susceptible to that kind of injury, if necessary. The other complications are also generally described as “rare”.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Coast Family Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Signature of Patient

_____

Parent or Guardian's signature

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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column, which causes alterations or nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All question regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore I accept chiropractic care on this basis.

_____ _____

(sign) (date)

Consent to evaluate and adjust a minor child:

I,_____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge, I am not pregnant and Dr. Escobedo and his associate(s) have my consent to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

_____ _____

(sign) (date)