

Individualized Healthcare

It's all about the uniqueness of your child

PATIENT INFORMATION

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Sex: Male Female

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

Home #: _____ Cell #: _____ email: _____

Where do you prefer to receive calls? Home Office Cell No preference

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____

Relationship to Patient _____ Phone #: _____

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

PRESENT HEALTH CHALLENGES(s):

For what health challenge(s) is your child here for?

What do you feel is the cause of your child's problem?

When did you first notice this sign of body dysfunction?

Is this dysfunction getting progressively worse? Yes No

If yes, why do you think so?

What are the most significant measures you have taken to date to improve your child's present health challenge?
Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent colds/ congestion	<input type="checkbox"/> Upper respiratory Infections	<input type="checkbox"/> Asthma
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Infected/sore Throat	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Laryngitis
<input type="checkbox"/> Colic	<input type="checkbox"/> Reflux/spitting up	<input type="checkbox"/> U-tract infections	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Poor digestion/ (constipation/diarrhea)	<input type="checkbox"/> Thrush mouth/ Chronic diaper rash	<input type="checkbox"/> Eczema/psoriasis/ Other skin rashes	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Irregular sleep Patterns	<input type="checkbox"/> Night terrors	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Headache
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Bruising	

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? Yes No
If yes, for what reason and for how long?

Has your child ever been hospitalized? Yes No
If yes, why and when? (Please list in chronological order)

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

Please check any of the following sports activities that your child is engaged in.

___ Football	___ Lacrosse	___ Soccer	___ Track/Field
___ Bowling	___ Tennis	___ Hockey	___ Volleyball
___ Baseball/Softball	___ Skateboarding	___ Snowboarding	___ Skiing
___ Gymnastics/ Trampoline	___ BMX/Motorcross	___ Swimming	___ Golfing

Has your child ever been injured while playing sports? ___ Yes ___ No

If yes, what type of injury(s) occurred?

Recent research reveals that 30% of American children are obese with more than 50% of all US children overweight.
On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

___ 1 ___ 2 ___ 3 ___ 4 ___ 5	___ 1 ___ 2 ___ 3 ___ 4 ___ 5	___ 1 ___ 2 ___ 3 ___ 4 ___ 5	___ 1 ___ 2 ___ 3 ___ 4 ___ 5
<u>Non-Complex Carbohydrates</u> Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy	<u>Complex Carbohydrates</u> Fruits & Vegetables	<u>Protein</u> Nuts, Seeds, Meats, Eggs	<u>Fats</u> Dairy Products

Please list the (3) most common foods eaten by your child each day.

How many times per month does your child eat fast food? _____

What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ___ Yes ___ No
If yes, what type of artificial sweeteners does your child use? _____

Was your child breast fed? ___ Yes ___ No If yes, for how long? _____

Was your child formula fed? ___ Yes ___ No If yes, what type and for how long? _____

At what age did you introduce solid foods into your child's diet? _____

What type(s)? _____

Has your child exhibited any tolerance and/or allergy to any specific food? Yes No

If yes, please list all foods. _____

Has your child been tested for allergies? Yes No

If yes, how were the tests performed? _____

What were the results? _____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)

Has your child received treatment for any type of allergy? Yes No

If yes, what type of treatment?

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative

Date

Print Name of Parent, Guardian or Personal Representative

Relationship to patient

Alicia Bolzenius D.C.
611 Hwy. 50 West
Union, MO 63084
(636) 584-7900
Fax: (636) 583-8897

Consent to Treat a Minor Child

I hereby authorize Dr. Alicia Bolzenius and whomever she may designate as her assistants to administer treatment, as she so deems necessary to _____
_____ this _____ day of _____.

Signature of Parent or Guardian: _____

Witnessed: _____

Date: _____