Inspiral Arts

Date_____
Patient DOB_____
Age_____Yrs_____Mos

A. Pediatric Patient Information

Patient Name _____
Parent/Guardian Name_____
Address_____
City_____ State _____Zip _____
Phone_____
Email_____
Occupation (P/G)_____
Phone_____
Physician/Care provider_____
Phone_____
Permission to consult Dr. Initials_____Date_____

B. Current Health Information

Health concerns and expectations for treatment.

_____
_____
_____

Pain location and Intensity (0-10) _____

_____
_____

Constant or Intermittent ↑ or ↓ w/activity

Medications_____
_____
_____

C. Health History

List and explain including dates.

Surgeries _____
_____

Diagnostic/Procedures_____
_____
_____

Injuries_____
_____
_____
_____

Illnesses _____
_____
_____

Emotional trauma (Mother during pregnancy)
_____
_____

Complications during pregnancy_____
_____

Emotional trauma (Child)_____
_____

Birth/Infant history Check and circle.

Natural birth	
Fertility enhanced pregnancy	
Premature	
Pitocin or Epidural	
Long or Fast labor	
Complications:	
Vacuum/Forceps	
V-Back	
C-section	
Breast or Formula fed	
Latch issues	
Colic	
Asymmetrical movements	

Systems Check Current/Past/Family Hx

Circle and check	C	P	F
Skin:			
Rashes/Eczema/Psoriasis			
Cradle cap			
General			
Sleep disturbances			
Infections			
Fever			
Cancer/Tumors			
Benign			
Malignant			

Cardiovascular			
Heart disease			
High/Low blood pressure			
Irregular hear beat			
Respiratory			
Asthma			
Pneumonia			
Bronchitis			
Allergies			
Cold/cough			
Musculoskeletal			
Scoliosis			
Spinal problems			
Sprains/Strains			
Spasms/Cramps			
Stiff or Painful joints			
Weak or sore muscles			
Neck/Shoulder/Arm pain			
Low back/Hip/Leg pain			
Other:			

Digestive/Elimination			
Abdominal pain			
Reflux			
Gas/Bloating			
Food allergies			
Constipation/Diarrhea			
Bowel disease			
Liver disease/Gallstones			
Appetite/Nausea			
Bladder/Kidney			

Nervous system			
Headaches/migraine			
Head injury/concussion #			
Plagiocephaly			
Dizziness/Vertigo/Balance			
Numbness, tingling			
Paralysis			
Seizure/Epilepsy			
ADD			
Sensory integration issues			
Developmental delay			
Genetic disorder			
ENT, ear, nose, throat			
Hearing loss			
Ear tubes			
Vision loss			
Tonsillitis/removal			
Tongue/Lip tie			
Dental issues			
Immune/Lymphatic			
Edema			
Inflammation			
Autoimmune disorders			

Pediatric Consent for Care

I,_____, parent or legal guardian of_____ give my consent for manual therapy treatment. I have reported all health conditions of this child that I am aware of and will inform my therapist of any changes in their health. I agree to participate fully as a member of my child's/Guardian's health care team. I promise to inform the therapist any time I feel the child's well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Signature of Parent/Guardian:

_____ Date_____