Consent for Treatment of a Minor

I hereby authorize Dr. Tagliarini and whomever he/she may designate as assistants to administer examinations and Chiropractic care as deemed necessary to my child.

Parent or Guardian’s Name (printed): __________________________________________

Parent or Guardian’s Signature: __________________________________________

Please share the names of your child’s healthcare providers & check whether or not you would like to share medical records with:

Pediatrician __________________________________________

Midwife/OB _________________________________________

Lactation Consultant _____________________________________

Other __________________________________________________

Parent/Guardian 1 Signature: __________________________

Parent/Guardian 2 Signature: __________________________

1. Describe your child’s current symptoms:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

2. How Long? __________________________

3. How Frequent? __________________

4. What treatments have you tried for current symptoms? _________________________________________________

5. What makes symptoms better? _________________________________________________________________

6. What makes it worse? ________________________________________________________________
7. Birth History: *(check all that apply)*

- [] Born Premature? How Early ______
- [] Born on time ?
- [] Born Past Due? How Late? ______
- [] Induced labor
- [] Vaginal birth at home
- [] Vaginal birth at Hospital
- [] Vaginal birth at Birthing Center
- [] Scheduled Cesarean
- [] Emergency Cesarean
- [] Epidural used
- [] Forceps used
- [] Vacuum extraction used

8. Feeding History: *(check all that apply)*

- [] Nursed? How Long ______
- [] Formula Fed?
- [] Both?
- [] Tongue Tie?
- [] Lip Tie?
- [] Lactation Consultant Used?

9. Other History: *(check all that apply)*

- [] ADD/ ADHD
- [] Frequent Crying Spells
- [] Scoliosis
- [] Frequent Ear infections
- [] Frequent Fevers
- [] Allergies
- [] Constipation/Diarrhea
- [] Sleeping problems
- [] Headaches
- [] RSV
- [] Antibiotic Use
- [] Growing Pains
- [] Motor or Speech Delays
- [] Tonsillitis
- [] Bed Wetting
- [] Frequent Illness (cold/sick)
- [] Other ________________

10. Pediatrician: ___________________________  11. Date of Last Medical Physical ___________________________

12. *Indicate if an immediate family member has had any of the following:*

(1) Rheumatoid Arthritis  (2) Heart Problems  (3) Diabetes  (4) Cancer  (5) Lupus  (6) Other: __________

13. *List all prescription and over-the-counter medications, nutritional/herbal supplements your child is taking:*

________________________________________________________________________________________________________
________________________________________________________________________________________________________

14. *List all the times your child has been hospitalized & all surgeries:*

________________________________________________________________________________________________________
________________________________________________________________________________________________________

15. ANY & ALL LIFETIME TRAUMA HISTORY to head, neck, or back (such as concussion, automobile accident, sports injury, etc)...EVEN IF YOUR CHILD DID NOT HAVE ANY SYMPTOMS OR TREATMENT, STILL NOTE THE TRAUMA PLEASE.

________________________________________________________________________________________________________

Parent/Guardian Signature__________________________ Date__________________________