KNIGHT *Family* CHIROPRACTIC

PEDIATRIC OUTCOME ASSESSMENT

Patient Name______________________________________ Date______________________

NO SYMPTOMS ____ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your child's level of problem.

1. What was the chief symptom or reason you brought your child to our clinic? ____________
   ____

2. How do you classify your child's improvement so far since beginning their care?
   Excellent _________ Good_________ Fair_________ Poor_________

3. Rate your child's improvement on a scale of 1 to 10, with 10 being the best:____________

4. Which of the following symptoms have improved for your child?
   - ❑ Colic/Frequent Crying ❑ Reflux ❑ Constipation ❑ Ear Infections
   - ❑ Sleeping Problems ❑ Allergies ❑ Headaches ❑ Bed Wetting
   - ❑ Head Rotation/Torticollis ❑ Asthma ❑ Leg Pain ❑ Posture
   - ❑ Latching/Breast Feeding Difficulty ❑ Learning Difficulties/ADHD
   - ❑ Other(s):____

5. Which of the following symptoms does your child still have?
   - ❑ Colic/Frequent Crying ❑ Reflux ❑ Constipation ❑ Ear Infections
   - ❑ Sleeping Problems ❑ Allergies ❑ Headaches ❑ Bed Wetting
   - ❑ Head Rotation/Torticollis ❑ Asthma ❑ Leg Pain ❑ Poor Posture
   - ❑ Latching/Breast Feeding Difficulty ❑ Learning Difficulties/ADHD
   - ❑ Other(s):____

6. What is easier for your child to do now?
   ❑ Sit ❑Crawl ❑ Walk ❑ Sleep ❑ Eat/Feed ❑ Sports ❑ School

7. Is there any confusion or question(s) about any phase of your child's progress or other condition(s) your child has that we have not discussed that you would like to discuss at this time? ______ If yes, please explain:____
   ____

8. For Wellness Care for your child, would you prefer:
   _____ 1 time per week _____ 2 times per month _____ 1 time per month

X____

Parent/Legal Guardian Signature

KNIGHT FAMILY CHIROPRACTIC

☐ DURANT, OK 1004 N. 19th Ave., Bldg. 2 Durant, OK 74701 P: 580.448.4412	☐ DENISON, TX 3230 S. Eisenhower Pkwy. Denison, TX 75020 P: 903.465.1881	☐ SHERMAN, TX 2021 N. Heritage Pkwy. Sherman, TX 75092 P: 903.892.3471	☐ ANNA, TX 1108 W. White St., Ste 100 Anna, TX 75409 P: 469.840.4111

PATIENT INFORMATION:

DATE: ______________________________

CHILD'S NAME: ____ DOB: ______________________________

PARENT/GUARDIAN'S NAME: ____

CELL #: ______________________________________ CELL CARRIER: ____

ADDRESS: ____

EMAIL ADDRESS: ____

HAS YOUR CHILD HAD PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DR'S NAME: ______________________________ LAST DATE SEEN: ________________________

WERE X-RAYS TAKEN? ☐ YES ☐ NO WHO IS YOUR PEDIATRICIAN?____

PRENATAL HISTORY:

IS YOUR CHILD ADOPTED? ☐ YES ☐ NO

DID YOU HAVE ANY COMPLICATIONS? ☐ YES ☐ NO IF YES, PLEASE ELABORATE:_________________________________

DID YOU SMOKE? ☐ YES ☐ NO DID YOU CONSUME ALCOHOL? ☐ YES ☐ NO

DID YOU TAKE MEDICATION? ☐ YES ☐ NO REASON FOR MEDICATIONS:

____

BIRTH HISTORY:

DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? ☐ YES ☐ NO

WHAT WAS THE FREQUENCY: ____

PLACE OF BIRTH: ☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

PROVIDER: ☐MIDWIFE ☐OB/GYN ☐ OTHER

____

TYPE OF BIRTH: ☐VAGINAL ☐ C-SECTION

WERE PAIN MEDICATIONS USED? ☐ YES ☐ NO EPIDURAL? ☐ YES ☐ NO

WAS LABOR INDUCED? ☐ YES ☐ NO IF YES, WHY: ____

WHAT POSITION DID YOU DELIVER IN? ☐SQUATTING ☐ ON BACK ☐ OTHER

____

BIRTH TRAUMA? ☐ DOCTOR ASSISTED ☐ TWISTING &/OR PULLING ☐VACUUM EXTRACTION ☐ FORCEPS
☐ CORD AROUND NECK

NEWBORN TRAUMA (MEDICAL PROCEDURES & TESTS):

APGAR SCORE: BIRTH ____/10 5-MINS ____/10 ☐ UNSURE

DID YOUR CHILD HAVE A MISSHAPEN SKULL/HEAD? ☐ YES ☐ NO

WERE THERE PURPLE MARKINGS ON THEIR FACE? ☐ YES ☐ NO

DID YOU BREASTFEED YOUR CHILD? ☐ YES ☐ NO

DOES YOUR CHILD PREFER ONE BREAST OVER THE OTHER? ☐ YES ☐ NO IF YES, WHICH SIDE: ☐ RIGHT ☐ LEFT

DOES YOUR CHILD HAVE FOOD ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE LIST:

____

HAS YOUR CHILD BEEN IMMUNIZED? ☐ YES ☐ NO

REASON FOR VACCINATION? ☐ INFORMED CONSENT ☐ RECOMMENDED ☐ DIDN'T KNOW I HAD A CHOICE

DID YOUR CHILD HAVE ANY ADVERSE REACTIONS TO THE VACCINATIONS? ☐ YES ☐ NO

WERE THEY REPORTED? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD ANY SURGERIES? ☐ YES ☐ NO

IF YES, PLEASE ELABORATE: ____

HAS YOUR CHILD BEEN ON ANTIBIOTICS? ☐ YES ☐ NO

IF YES, HOW OFTEN & FOR WHAT? ____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO IF YES, WHAT: ______________________________

IS YOUR CHILD CURRENTLY TAKING ANY VITAMINS? ☐ YES ☐ NO IF YES, WHAT: ______________________________

BABY/TODDLER (0-4):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A CHANGING TABLE ☐ FREQUENT CRYING SPELLS ☐ TUMBLE DOWNSTAIRS ☐ CAR ACCIDENT
☐ FALL OUT OF A CRIB ☐ FALL OFF PLAYGROUND EQUIPMENT ☐ PLAY IN A JOHNNY JUMPER ☐ TONSILLITIS
☐ FREQUENT EAR INFECTIONS ☐ REACTION TO VACCINES ☐ FREQUENT FEVERS ☐ FREQUENT DIARRHEA
☐ CONSTIPATION ☐ SLEEPING PROBLEMS ☐ REPEATED INFECTIONS (IE: STREP) ☐ COLIC ☐ (+ OR -) WEIGHT GAIN
☐ LATCHING/BREASTFEEDING DIFFICULTY ☐ OTHER (PLEASE EXPLAIN)____

____

CHILD (5-12):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A TREE ☐ FALL OFF A BICYCLE ☐ SPORTS ACCIDENT/INJURY ☐ CAR ACCIDENT ☐ STOMACH PAINS
☐ FALL OFF PLAYGROUND EQUIPMENT ☐ BED WETTING ☐ HYPERACTIVITY/AUTISM ☐ SCOLIOSIS
☐ LEARNING DIFFICULTIES ☐ ASTHMA ☐ ALLERGIES ☐ LEG/KNEE PAINS ☐ OTHER (PLEASE EXPLAIN)________________

____

ALL AGES:

WHICH OF THE ABOVE BOTHERS YOUR CHILD THE MOST? ____

WHEN DID IT BEGIN?____

IS IT GETTING WORSE? ☐ YES ☐ NO

IS THE PAIN: ☐ CONSTANT ☐ INTERMITTENT ☐CYCLIC

AFFECT ON ACTIVITY: ☐ NOT AT ALL ☐ SOMEWHAT ☐ ALWAYS

DOES YOUR CHILD PARTICIPATE IN ANY OF THE FOLLOWING?

☐ SOCCER ☐ FOOTBALL ☐ GYMNASTICS ☐KARATE ☐ HOCKEY ☐ LACROSSE ☐ BASKETBALL ☐ DANCE ☐ WRESTLING
☐ BASEBALL/SOFTBALL ☐ VOLLEYBALL ☐ TENNIS ☐ SWIMMING ☐ RUGBY
☐ OTHER: ____

HOW WOULD YOU RATE YOUR CHILD'S DIET? ☐ WELL BALANCED ☐ AVERAGE ☐ HIGH SUGAR/PROCESSED FOODS

DOES YOUR CHILD CONSUME ARTIFICIAL SWEETENERS? ☐ YES ☐ NO

FLUORIDATED WATER? ☐ YES ☐ NO

NUMBER OF HOURS YOUR CHILD SLEEPS? _______ PER DAY

SLEEP QUALITY? ☐ GOOD ☐ FAIR ☐ POOR

AUTHORIZATION TO TREAT A MINOR

I, ___________________________, THE UNDERSIGNING PARENT/GUARDIAN HAVING LEGAL CUSTODY/GUARDIANSHIP OF ____________________________, A MINOR, DO HEREBY AUTHORIZE, REQUEST AND DIRECT KNIGHT FAMILY CHIROPRACTIC AND WHOMEVER THEY MAY DESIGNATE AS AN ASSISTANT TO PERFORM IN JUDGEMENT ANY EXAMINATION AND CHIROPRACTIC DIAGNOSIS OR TREATMENT WHICH IS DEEMED NECESSARY. ANY SPECIFIC WRITTEN AUTHORIZATION YOU PROVIDE MAY BE REVOKED AT ANY TIME BY WRITING TO OUR OFFICE.

PATIENT: ____ SIGNATURE: _____________________________________

PRINT NAME PARENT/LEGAL GUARDIAN

DATE: ____