Optimal Health & Wellness Center

Fill all forms out completely. If a question does not pertain to you mark **N/A**.

Patient Information

Patient name _____

Today's date _____ Date of birth ___/___/___

Social Security # _____ - _____ - _____

Address _____

City _____ State _____ Zip _____

Name of Parent or Guardian: _____

Are both parents living with the child? ❑ Yes ❑ No

If not, will both parents be caring for the child? ❑ Yes ❑ No

How did you hear about our office? _____

_____

List doctors consulted within the past year:

1. Name: _____ When: _____
Reason for visit? _____

2. Name: _____ When: _____
Reason for visit? _____

Contact Information

Employer/School (___) _____

Employer/School phone number (___) _____

Employer/School address _____

Home phone (___) _____

Cell phone (___) _____

Work/Other phone (___) _____

Email address _____

May we contact you via (please check for all applicable):

❑ Home phone ❑ Cell ❑ Work phone ❑ Email

In case of emergency please contact:

Name _____

Relationship _____

Home phone (___) _____

Whom may we thank for the referral? _____

Patient Condition

List your child's developmental disorder according to severity	Date parent 1st noticed symptom	Date Diagnosed	Is disorder getting better or worse?
1.			
2.			
3.			

1. Specific goals you, as a parent, want to see:
Improve: _____
Behaviors you do not want to see anymore: _____
_____

2. Have any other family members been diagnosed with Autism Spectrum Disorders, ADD, ADHD or Dyslexia? ❑ Yes ❑ No
If yes, please list relationship(s): _____

3. Have any other family members been diagnosed with Autoimmune Disease, Rheumatoid Arthritis, Lupus, Scleroderma, MS, ALS, Thyroid Disease, Autoimmune Diabetes, Grave's or others? _____ ❑ Yes ❑ No
If yes, please list relationship(s): _____

Health History

1.Mom's Health During Pregnancy

a.Was mom over weight? ❑ Yes ❑ No If yes, please explain: _____

b.Was mom sick? ? ❑ Yes ❑ No If yes, please explain: _____

c.How many births has the mother had? ? ❑ Yes ❑ No If yes, please explain: _____

d.How many miscarriages? ? ❑ Yes ❑ No If yes, please explain: _____

e.Did mom use fertility drugs? ? ❑ Yes ❑ No If yes, please explain: _____

f. Health of siblings? ? _____

Maternal stress during pregnancy: Divorce? ❑ Yes ❑ No Car accident? ❑ Yes ❑ No Physical Trauma? ❑ Yes ❑ No

Broken Bones? ❑ Yes ❑ No If yes, please explain: _____

_____

Death in family? ❑ Yes ❑ No Job loss? ❑ Yes ❑ No

Mom's exposure to toxins? (example: mold, pesticides) ❑ Yes ❑ No If yes, explain: _____

Known infection(s) mom had during pregnancy: ❑ Yeast ❑ Bacterial ❑ Viral ❑ None

Did mom drink alcohol during pregnancy? ❑ Yes ❑ No Smoke? ❑ Yes ❑ No Drink coffee? ❑ Yes ❑ No Have excessive bleeding? ❑ Yes ❑ No Vomiting? ❑ Yes ❑ No

2. Birthing Process:

What type of delivery? ❑ Vaginal ❑ Cesarean

Any birth trauma? ❑ Yes ❑ No If yes, please explain: _____

Was delivery induced? ❑ Yes ❑ No Natural? ❑ Yes ❑ No Epidural? ❑ Yes ❑ No

APGAR score: _____at one minute _____at 5 minutes

3. Infant toxic exposure:

Mold in house? ❑ Yes ❑ No Pesticides? ❑ Yes ❑ No Other?_____

4. Infections in first two years of child's life:

Type of Infection	Age at onset	Type of Infection	Age of onset
1.		4.	
2.		5.	
3.		6.	

Is child on antibiotics now? ❑ Yes ❑ No If yes, what kind?_____

At what age did child first receive antibiotics?_____ What age was the first illness? _____

5. Please list ALL surgeries and the child's age at time of surgery:_____

6. Motor Development

Child's age when: First held head up _____ Rolled over_____ Sat up_____ Crawled_____ Walked_____

Did child display "cute" or out of the ordinary behavior when learning to crawl of walk? ❑ Yes ❑ No If yes, please explain:

Age potty trained:_____ Age stopped wetting bed:_____ Age of first words "mama"/ "dada" _____

Age child spoke 2 to 3 words together: _____ Has child lost language? ❑ Yes ❑ No If yes, at what age and how far did they regress? _____

How many words did child use in a sentence before regression? _____

Has child lost eye contact? ❑ Yes ❑ No If yes, at what age? _____

Did the child breast feed? ❑ Yes ❑ No If yes, for how long? _____Months

Age child began bottle-feeding? _____ Type of formula? ❑ Dairy based ❑ Soy based ❑ Self made ❑ Store bought

Age at which cow's milk was introduced: _____ Age wheat & grains were introduced: _____

7. Vaccine Response

Seizures? ❑ Yes ❑ No If yes, how long after did they begin? _____ How long did they last? _____

Bowel symptoms? ❑ Yes ❑ No If yes, explain: _____

Swelling at injections site? ❑ Yes ❑ No Fever? ❑ Yes ❑ No Skin rash? ❑ Yes ❑ No

8.Current Diet

What is your child eating now? Look back over the past 3 days and be as accurate as possible:

Does your child refuse to eat certain foods? ❑ Yes ❑ No Which foods? _____

_____

List all sweets your child eats: _____

_____

How many glasses of milk does your child drink per day? _____ How much cheese consumed per day? _____

Slices of bread per day? _____ Sodas per day? _____ Glasses of sweet tea per day? _____ Fruit juice? _____

How many sports drinks per day? _____ How many fast food meals per day? _____

Does your child crave/eat salty foods? ❑ Yes ❑ No

How much meat do they eat per day? _____ Ounces What type meat? _____

Vegetables per day? _____ Ounces What type Veggies? _____

9.GI Tract

Bowel movements per day? _____ Consistency? ❑ Hard/Constipated ❑ Formed/Normal ❑ Loose ❑ Watery/Diarrhea

Is child bloated? ❑ Yes ❑ No Dark circles under eyes? ❑ Yes ❑ No

Is your child's behavior worse during weather that is: ❑ Damp ❑ Hot ❑ Misty ❑ Moldy ❑ Other _____

Does your child wake up at night laughing or giggling? ❑ Yes ❑ No

Does your child put pressure or press on their stomach? ❑ Yes ❑ No

✳ **Has any immediate family had any of the following conditions or diseases?** ***Please check YES or NO for each one below.***

Ankylosing spondylitis	❑ Yes	❑ No	Cushing's disease	❑ Yes	❑ No	Knee surgery	❑ Yes	❑ No
Anxiety Disorder	❑ Yes	❑ No	Cystic medial necrosis	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
Arterial blockage	❑ Yes	❑ No	Crohn's disease	❑ Yes	❑ No	Marfan syndrome	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No
Bipolar disorder	❑ Yes	❑ No	Diabetes Type 1	❑ Yes	❑ No	Osteo-Arthritis	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	Diabetes Type 2	❑ Yes	❑ No	Osteoporosis /penia	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Digestive/Bowel problems	❑ Yes	❑ No	Parkinson's disease	❑ Yes	❑ No
Bowel/Bladder problems	❑ Yes	❑ No	Dizziness or vertigo	❑ Yes	❑ No	Polycyctic Ovary	❑ Yes	❑ No
Buzzing/ringing in ears	❑ Yes	❑ No	Fibromuscular dysplasia	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Carpal tunnel	❑ Yes	❑ No	Gout	❑ Yes	❑ No	STI/STD	❑ Yes	❑ No
Celiac disease (gluten)	❑ Yes	❑ No	Grave's Disease	❑ Yes	❑ No	Shoulder surgery	❑ Yes	❑ No
Chest pains	❑ Yes	❑ No	Hashimoto's Thyroiditis	❑ Yes	❑ No	Sjogren's syndrome	❑ Yes	❑ No
Chronic fatigue	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Spinal surgery	❑ Yes	❑ No
Cold hands or feet	❑ Yes	❑ No	Hepatitis - A B C D E	❑ Yes	❑ No	Stroke/TIA	❑ Yes	❑ No
Colitis/Diverticulitis	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	TMJ Dysfunction	❑ Yes	❑ No
Congestive Heart Failure	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Thyroid problems	❑ Yes	❑ No
Compression fractures	❑ Yes	❑ No	Hip replacement	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Connective tissue issues	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Other _____		
COPD	❑ Yes	❑ No	Irritable Bowl Disease	❑ Yes	❑ No	Other _____		
Cramping Muscles	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Other _____		

Permission to Test and Treat

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical administered by the staff at Optimal Health & Wellness Center, I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel.

Patient/Guardian Signature	Patient Printed Name	Date

The economic impact of attention-deficit/hyperactivity disorder in children and adolescents.

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Source

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Abstract

Using a cost of illness (COI) framework, this article examines the economic impact of attention-deficit/hyperactivity disorder (ADHD) in childhood and adolescence. Our review of published literature identified 13 studies, most conducted on existing databases by using diagnostic and medical procedure codes and focused on health care costs. Two were longitudinal studies of identified children with ADHD followed into adolescence. Costs were examined for ADHD treatment-related and other health care costs (all but 1 study addressed some aspect of health care), education (special education, 2 studies; disciplinary costs: 1 study), parental work loss (2 studies), and juvenile justice (2 studies).

Based on this small and as yet incomplete evidence base, **we estimated annual COI of ADHD in children and adolescents at $14,576 per individual (2005 dollars). Given the variability of estimates across studies on which that number is based, a reasonable range is between $12,005 and $17,458 per individual. Using a prevalence rate of 5%, a conservative estimate of the annual societal COI for ADHD in childhood and adolescence is $42.5 billion, with a range between $36 billion and $52.4 billion**. Estimates are preliminary because the literature is incomplete; many potential costs have not been assessed in extant studies. Limitations of the review and suggestions for future research on COI of ADHD are provided.

National peer reviewed research shows the impact of caring for a child with chronic health disorders.