Pediatric Chiropractic Care

PATIENT'S NAME:
FIRST:_____
MIDDLE:_____
LAST:___
PATIENT'S BIRTH DATE: _____/_____/_____
PATIENT'S GENDER: M ☐ F ☐
EMAIL ADDRESS:_____
REFERRED BY:_____
BIRTH WEIGHT:_____ **BIRTH HEIGHT:**_____'_____"
PATIENT'S SSN:_____
STREET:_____
CITY:_____
STATE:_____ **ZIP CODE:** _____
☐ **HOME PHONE**:_____
☐ **CELL PHONE**:_____
SERVICE PROVIDER:_____
☐ Check if you would like text messages.

PARENT/GUARDIAN'S INFORMATION:
FIRST:_____
MIDDLE:_____
LAST:_____
Is the Patient the Policy Holder? ☐ Yes ☐ No
POLICY HOLDER IS: ☐ PARENT ☐ GUARDIAN ☐ OTHER
FIRST NAME:_____ **LAST NAME:**_____
POLICY HOLDER'S BIRTH DATE: _____/_____/_____
POLICY HOLDER'S GENDER: M ☐ F ☐
INSURED'S SSN:_____
STREET:_____
CITY:_____
STATE:_____ **ZIP CODE:** _____
HOME PHONE:_____
CELL PHONE:_____

PLEASE CHECK BOX FOR PREFERRED PHONE NUMBER TO CALL.
REFERRED BY:_____
NUMBER OF SIBLINGS:_____
EMERGENCY CONTACT:_____ **PHONE:**(_____)_____-_____
IS PATIENT'S CONDITION RELATED TO: AUTO ACCIDENT? ☐ YES ☐ NO PLACE (STATE):_____
OTHER ACCIDENT? ☐ YES ☐ NO
Do you have a Claim Number**?** ☐ **Yes** ☐ **No**
INSURANCE: _____ ☐MEDICARE ☐MEDICAID ☐HSA / HRA ☐CASH ☐OTHER:_____
ETHNICITY/RACE: ☐ Caucasian ☐Hispanic or Latino ☐Black/African American ☐American Indian/Alaskan Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Two or more ☐Other:_____
PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other:_____
I would like to electronically have access to my health information: ☐ Yes ☐ No

PLEASE CHECK HEALTH TOPICS YOU WOULD LIKE TO LEARN MORE ABOUT.

☐ CLINIC ANNOUNCEMENTS, EVENTS AND 0FFERINGS ☐ STRESS MANAGEMENT ☐CHILDREN'S HEALTH ISSUES
☐WOMEN'S HEALTH ISSUES ☐EXERCISE & FITNESS ☐DIET & NUTRITION
☐WELLNESS TOPICS ☐HEADACHES & NECK PAIN ☐BACKACHES & SCIATICA

IF YOU HAVE HAD THIS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: _____/_____/_____
Reason for seeking Chiropractic care:_____
Other Doctors seen for this condition? Yes ____ No ____ If yes, what Specialty? _____
Prior treatment and outcome: _____
Other Health Problems: _____
Name of Pediatrician: _____ Date of last visit: _____/_____/_____
Reason for visit: _____
Has your child ever taken antibiotics? Yes ____ No____ If yes, condition treated: _____
Has your child ever been injured participating in contact sports (Soccer, Football, Martial Arts…) Yes____ No____
If yes, describe (Sprain, Broken, Head Trauma…) _____

Symptoms: Please check any current or past problems your child has on the list below:

____Asthma	____Diabetes	____High Blood Pressure	____Broken Bones
____ADHD	____Runny Nose	____Poor Appetite	____Sprains/Strains
____Backaches	____Itchy Eyes	____Hyperactivity	____Hernias
____Heart Condition	____Rashes	____Behavioral	____Neck Pain
____Chronic Earaches	____Unusual Moles	____Poor Memory	____Arm/Elbow Pain
____ Allergies	____Neuritis	____Insomnia	____Leg/Hip Pain
____Tuberculosis	____Digestive	____Nightmares	____Knee/Foot Pain
____ Diarrhea	____Sinus Trouble	____Bed Wetting	____Growing Pains
____Fever/Chills	____Cough/Wheeze	____Pain Urinating	____Joint Pain
____Frequent Colds	____Chest Pain	____Convulsions/Paralysis	____Scoliosis
____Arthritis	____Constipation	____Muscle Pain	____Blood Disorders
____Headaches	____Anemia	____Fainting	____Stomach Aches
____ Dizziness	____Rheumatic Fever	____Other_____	

PRESCRIBED MEDICINES: ☐ CHECK HERE IF YOU ARE NOT TAKING ANY MEDICATIONS.

MEDICATION i.e., Lipitor	**# OF MD REFILLS ISSUED**	**QUANTITY**	**STRENGTH** i.e., 10 mg	**DOSE FORM** i.e., Capsule	**MD'S INSTRUCTIONS** i.e., 1 per day

ARE YOU ALLERGIC TO ANY MEDICINES? PLEASE LIST EACH DRUG ON A NEW LINE:

☐ CHECK HERE IF YOU DO NOT HAVE ANY MEDICAL ALLERGIES.

NAME OF DRUG i.e., penicillin	**SYMPTOM** i.e., headache	**SEVERITY** **Mild / Mild to Moderate / Moderate / Moderate to Severe / Severe / Fatal**

Has your child ever been involved in a car accident? Yes ____ No ____ If yes, Date: ____/____/____ Injury: _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Yes ____ No____
Other traumas not described above? Yes ____ No ____ If yes, Date: ____/____/____ Type of trauma: _____
Prior surgery: Yes ____ No ____ If Yes, Date: ____/____/____ Type of Surgery: _____
Menarche: Yes ____ No ____ Age: _____

Prenatal History:

Location of Birth: Home ____ Birthing Center ____ Hospital ____ Stepchild____ Adopted ____
Complications during pregnancy: Yes ____ No ____ If yes, list complications: _____
Ultrasounds during pregnancy: Yes ____ No ____ If yes, number of ultrasounds: _____
Medications during pregnancy/delivery: Yes ____ No ____ If yes, please list: _____
Cigarette/Alcohol use during pregnancy: Yes ___ No ____
Birth intervention: Forceps ____ Vacuum ____ Caesarian ____ Why? _____
Complications during delivery: Yes ____ No____ If yes, list complications: _____
Genetic disorders or disabilities: Yes ____ No ____ If yes, Please list: _____
Birth Weight _____ Birth Length _____ APGAR scores: 1 min _____ 5 min_____

Feeding History:

Breast Fed: Yes ____ No____ If yes, how long: _____ Formula Fed: Yes ____ No ____ If yes, how long: _____
Type: _____ Introduced to solids at: _____months. Cow's milk at _____months.
Food/juice allergies or intolerances: Yes ____ No ____ If yes, please list: _____

Developmental History:

Sleep (Hrs per night): _____ Number of naps: _____ Length: _____ Problems Sleeping: _____
At what age was your child able to:
Crawl _____ Sit Alone _____ Stand Alone _____ Walk Alone _____ Say Words _____

Childhood Diseases:

Chicken Pox ____ - Age _____ Mumps ____ - Age _____ Rubella ____ - Age _____ Whooping Cough ____ - Age ____
Measles ____ - Age ____ Meningitis ____ - Age ____ Tuberculosis ____ - Age ____ Other _____ - Age

Vaccination History:

Recommended schedule? Yes __ No __
Alternative schedule? Yes __ No __
Adverse Reactions to any vaccine? Yes __ No __ If yes, please list: _____

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?
Secret Question:_____ Secret Answer:_____

Patient Signature:_____ Date_____
Parent/Guardian Signature if Patient is a Minor:_____ Date:_____
I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I, _____, being the parent or legal guardian of above patient, hereby grant permission for my child to receive chiropractic care.
Signed:_____ Witness:_____ Date:_____/_____/_____
OFFICE USE ONLY: TA ☐ MED/ALLERGIES ☐ Entered by:_____ Date:____/_____/20____ Time: _____:_____
Blood pressure:_____/_____ **Height**:_____'_____ **Weight**:_____ **Pulse:**_____