****

**Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PEDIATRIC DEVELOPMENT INFORMATION**

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Age: \_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Gender: M F Weight: \_\_\_\_lbs. Height \_\_\_\_\_in.

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we thank for referring you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **HEALTH CONCERNS**

Reason for pursuing care: Wellness Check-up Injury / Accident Other Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors seen for this condition? Yes No What are doctor’s names and prior treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Ear infections | \_\_\_ Scoliosis | \_\_\_ Chronic colds | \_\_\_ Headaches |
| \_\_\_ Allergies | \_\_\_ Digestive issues | \_\_\_ ADHD / ADD | \_\_\_ Recurring fevers |
| \_\_\_ Colic | \_\_\_ Growing / back pains | \_\_\_ Bed wetting | \_\_\_ Temper tantrums |
| \_\_\_ Seizures | \_\_\_ Asthma | \_\_\_ Car accidents: | \_\_\_ Walking problems |

Check any of the following conditions that currently apply:

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_

Previous chiropractic care? Yes No Last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of doses of antibiotics your child has taken: Past 6 months \_\_\_\_\_\_\_ Total lifetime \_\_\_\_\_\_\_\_

Present prescription drugs / dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past prescription drugs / dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Food / juice allergies or intolerances? Yes No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **BIRTH HISTORY**

Complications during pregnancy / delivery? Yes No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Intervention? Forceps Vacuum extraction Caesarian section

Genetic disorders / disabilities? Yes No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **DEVELOPMENTAL HISTORY**

At what age was your child able to:

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_ Respond to stimuli | \_\_\_\_\_\_\_\_ Cross crawl | \_\_\_\_\_\_\_\_ Stand alone |
| \_\_\_\_\_\_\_\_ Respond to visual stimuli | \_\_\_\_\_\_\_\_ Hold head up | \_\_\_\_\_\_\_\_ Walk alone |
| \_\_\_\_\_\_\_\_ Sit up |  |  |

**According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).**

Did you child have a fall similar to what was described above? Yes No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been involved in any sports? Yes No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all past broken bones, surgeries or hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other traumas not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like us to know about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEGMENTS: Please read each statement and initial your agreement on the left.**

**Insurance Information**

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for

\_\_\_\_\_\_ me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

**Privacy Policy**

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more

\_\_\_\_\_\_ complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent,
* The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

**Appointment Reminders and Health Care Information Authorization**

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related

\_\_\_\_\_\_ information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

**By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature Date Doctor Signature Date

**FAMILY HEALTH HISTORY**

Your child’s spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

**Please check off any of the conditions below that you and your family have or have had in the past: \* Write C if current issue or P if past issue**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Patient | Sibling(s) | Mother | Father | Other |
| Asthma / Allergies |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| TMJ |  |  |  |  |  |
| Acid Reflux |  |  |  |  |  |
| Epilepsy / Seizure |  |  |  |  |  |
| Ulcers |  |  |  |  |  |
| Dizziness |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Vertigo |  |  |  |  |  |
| Neurological Problem |  |  |  |  |  |
| Menstrual Irregularity |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Lupus |  |  |  |  |  |
| Fatigue |  |  |  |  |  |
| Numbness |  |  |  |  |  |
| Ear Infection |  |  |  |  |  |
| Sciatica |  |  |  |  |  |
| Heart Condition |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Thyroid Problem |  |  |  |  |  |
| Kidney Problem |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Disc Problem |  |  |  |  |  |
| Neck / Back Pain |  |  |  |  |  |
| Irritable Bowel |  |  |  |  |  |
| Digestive Problem |  |  |  |  |  |

**Circle any of the following conditions your child currently has or in the past:**

STROKE CANCER HEART DISEASE SEIZURES SPINAL FRACTURE SCOLIOSIS DIABETES

RHEUMATOID ARTHRITIS AIDS/HIV GENETIC DISEASE OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature Date Doctor Signature Date