



# PEDIATRIC HISTORY FORM

Dear **New Patient**,

**Date:** \_\_\_\_\_

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_

Names of Parents / Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Guardian Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Purpose For Contacting Us?** \_\_\_\_\_

Other Doctors Seen for this Condition: Y N Doctors' Names and Prior Treatments: \_\_\_\_\_

Other Health Problems? \_\_\_\_\_

Check any of the Following Conditions Your Child has suffered from During the Past Six Months:

- |                    |                    |              |                  |                      |
|--------------------|--------------------|--------------|------------------|----------------------|
| Ear Infections     | Scoliosis          | Seizures     | Chronic Colds    | Headaches            |
| Asthma / Allergies | Digestive Problems | ADHD/ADD     | Recurring Fevers | Growing / Back Pains |
| Colic              | Bed Wetting        | Car Accident | Temper Tantrums  | Other _____          |

Family History: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: \_\_\_\_\_, Total During His / Her Lifetime: \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: \_\_\_\_\_, Total During His / Her Lifetime: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

**Prenatal History:**

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications During Pregnancy ? Y N List: \_\_\_\_\_

Ultrasounds During Pregnancy ? Y N Number: \_\_\_\_\_

Medications During Pregnancy / Delivery ? Y N List: \_\_\_\_\_

Cigarette / Alcohol Use During Pregnancy: Y N

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Emergency Caesarian Section Planned Caesarian Section

Complications During Delivery? Y N List: \_\_\_\_\_

Genetic Disorders or Disabilities: Y N List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Score: \_\_\_\_\_

### Feeding History:

Breast Fed: Y N How Long: \_\_\_\_\_

Formula Fed: Y N How Long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to Solids at: \_\_\_\_\_ months,

Cows' milk at \_\_\_\_\_ months

Food / Juice Allergies or Intolerances: Y N List: \_\_\_\_\_

### Developmental History:

During the following times your child's spine is 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). At what age was your child able to:

\_\_\_\_\_ Respond to Sound

\_\_\_\_\_ Crawl, how long: \_\_\_\_\_

\_\_\_\_\_ Respond to Visual Stimuli

\_\_\_\_\_ Stand Alone

\_\_\_\_\_ 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, etc.). Was this the case with your child? Y N

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? Y N List: \_\_\_\_\_

Has Your Child Ever Been Involved in a Car Accident? Y N List: \_\_\_\_\_

Has Your Child Been Seen on an Emergency Basis? Y N List: \_\_\_\_\_

Other Traumas Not Described Above? Y N List: \_\_\_\_\_

Prior Surgery: Y N List: \_\_\_\_\_

Menarche(first period): Y N Age: \_\_\_\_\_

### Childhood Diseases:

Chicken Pox Y N Age \_\_\_\_\_

Mumps Y N Age \_\_\_\_\_

Rubella Y N Age \_\_\_\_\_

Whooping Cough Y N Age \_\_\_\_\_

Measles Y N Age \_\_\_\_\_

Other Y N Age \_\_\_\_\_

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.  
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

# FINANCIAL POLICIES

*We are committed to great service...and expect to be fairly paid for it.*

It is our firm office policy that all services rendered in this office are charged directly to you, the client. You are personally and fully responsible for all payments regardless of whether or not we accept insurance assignment. Realize that insurance companies do not guarantee payment. Each case is subject to review and individualized rulings.

By signing below, you agree to keep your balance (co-pay or otherwise) at \$150 or less, unless other arrangements were made. If you are an insurance assignment patient, you agree to first meet your deductible in full and pay your co-insurance at the time service is rendered or at the end of each week.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

Returned checks and balances over 30 days may be subject to additional collection fees and interest charge of 1.5% per month

## ***WE WILL FILE YOUR INSURANCE FOR YOU:***

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Gonstead Clinic of Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

***Thanks for your cooperation, we will always give you 100%...thanks for doing the same.***

By signing, I understand and agree to comply with each of the Financial Policies outlines above.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

## **RELEASE OF MEDICAL INFORMATION**

I hereby authorize the release of any medical information necessary to process any insurance claim.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **TREATMENT OF A MINOR**

I as legal guardian of patient do authorize appropriate chiropractic treatment.

Signature \_\_\_\_\_