YOUNG CHILD HEALTH HISTORY

E 320 CHIROPRACTIC

Child's Name: _____

Birth Date: _____ **Age:** _____

Gender: _____ **Height:** _____ft _____inches **Weight:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____ **Cell Phone #:** _____

Pediatrician/Family MD: _____

How did you hear about our office? _____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship: _____ **Cell Phone #:** _____

Social Security #: _____ - _____ - _____

Parent/Guardian Name: _____

Relationship: _____ **Cell Phone #:** _____

Social Security #: _____ - _____ - _____

PEDIATRIC HISTORY

Birth Weight: _____ **Birth Height:** _____ **Duration of Gestation**: _____ weeks

Hospital/Birthing Center: ☐ Home ☐ Medical ☐ Midwife

Birth Intervention: ☐ Forceps ☐ Vacuum ☐ C-Section

Was the Delivery Normal? ☐ Yes ☐ No → **Please explain:** _____

CHEMICAL STRESSORS

Did Your Child Receive Vaccinations: ☐ No ☐ Yes→ ☐ Recommended Schedule ☐ Delayed Schedule

Vaccine Reaction: ☐ No ☐ Yes→Explain _____

Does Your Child Receive Annual Flu Shots: ☐ No ☐ Yes

Has Your Child had Antibiotics? ☐ No ☐ Yes→ How many courses in last 6 months? _____

Reason for antibiotics: _____

Medications: ☐ No ☐ Yes→List: _____

Child's Diet:

Bottles of water/day:	☐ 0	☐ 1-3	☐ 4-6	☐ 7+
Cow's Milk:	☐ 0	☐ 1-3	☐ 4-6	☐ 7+
Juice:	☐ 0	☐ 1-3	☐ 4-6	☐ 7+
Sweet/Unsweet Tea:	☐ 0	☐ 1-3	☐ 4-6	☐ 7+
Soda/Energy Drinks:	☐ 0	☐ 1-3	☐ 4-6	☐ 7+

Does your child eat dairy?	☐ No	☐ Yes	☐ Trying to Decrease
Does your child eat refined sugars (white bread, pasta, cereal)?	☐ No	☐ Yes	☐ Trying to Decrease
Does your child eat boxed/frozen food?	☐ No	☐ Yes	☐ Trying to Decrease
Does your child eat school lunch?	☐ No	☐ Yes	☐ Sometimes
Does your child eat fresh fruit?	☐ No	☐ Yes	☐ Selective
Does your child eat vegetables?	☐ No	☐ Yes	☐ Selective

Describe your child's diet: ☐ Eats Everything ☐ Tries most foods ☐ Selective ☐ Very Selective

Food Allergies/Intolerances: ☐ No ☐ Yes→ List: _____

EMOTIONAL STRESSORS

Child Sleeping Difficulties (ex. Night terrors, sleep walking, etc.) ☐ No ☐ Yes→ Explain: _____

Child Behavior Problems: ☐ No ☐ Yes→ Explain: _____

Average Amount of TV/Technology/**Day**: _____hours

Average Amount of Time Spent Outdoors/**Day:** _____ hours

TRAUMATIC STRESSORS

Majors Falls/Accidents: ☐ No ☐ Yes→ List: _____

Surgeries: ☐ No ☐ Yes→ List: _____

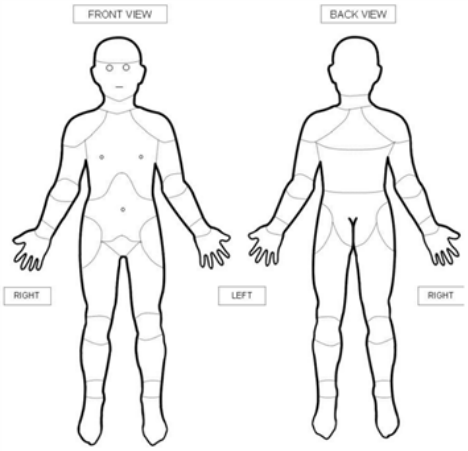
Hospitalizations: ☐ No ☐ Yes→ List: _____

Does Your Child Play Sports? ☐ No ☐ Yes→List: _____ Hours/Week: _____

Weight of Child's Back Pack: _____lbs.

PRESENT PEDIATRIC HEALTH

Purpose of this Visit: ☐ Wellness Visit ☐ Injury/Accident ☐ Other _____



If Your Child is Experiencing Pain:

Location of Pain: _____ Duration**: (how long?)** _____

What brought on the Pain? _____

When did the Problem Begin? ☐ Unknown ☐ Gradual ☐ Sudden

Ever had this Problem Before: ☐ No ☐ Yes→ _____

What makes it Better? _____

What makes it Worse? _____

How is this Problem NOW?

☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Is there a time of day where the pain is more noticeable? _____

Bowel or Bladder Problems since this problem started? ☐ No ☐ Yes→ _____

Have you seen **other doctors** for this problem? ☐ No ☐ Yes→ _____

Limitations as a result of problem? ☐ No ☐ Yes→ _____

Medications for this Problem? ☐ No ☐ Yes→ _____

Accidents/Falls/Past Injuries

HAS YOUR CHILD EVER SUFFERED FROM: ***Check ALL that apply:***

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Ear Tubes
☐ Tonsils Removed	☐ Adenoids Removed.	☐ Fall off swing	☐ Concussion
☐ Fall from bed/couch	☐ Fall down stairs	☐ Fall off bike	☐ Fall from hover board
☐ Fall off skateboard	☐ Trampoline Injury	☐ Fall off playground equipment	

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at E320 Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I understand and agree that the accident and health insurance policies are an arrangement between an insurance carrier and myself. I understand that E320 Chiropractic LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered are charged to me directly and that I am personally responsible for all charges at the time of service.

Parent/Guardian Signature: _____Date: _____

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Name: _____

Release of Information: I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Parent/Guardian: _____ ☐ Information is not to be released to anyone.

☐ Other: _____

This Release of Information will remain in effect until terminated by me in writing.

Messages: (If we are unable to reach you)

☐ You may leave a detailed message ☐ Please leave a message asking me to return your call

☐ Send a text Message ☐ Send an email

Signed: _____ **Date:** _____

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files.

At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is $15.00.** This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day. Please Note: x-rays are utilized in this office to help locate and analyze vertebral subluxations.

These x-rays are not used to investigate medical pathology. The doctor of E320 Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By Signing Below, you are agreeing to the above terms and conditions.

Signed: _____ **Date:** _____

Female Patients: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken at E320 Chiropractic.

Signed: _____ **Date:** _____