PEDIATRIC HEALTH HISTORY

E 320 CHIROPRACTIC

Child's Name: _____

Birth Date: _____ **Age:** _____ **Gender:** _____

Height: _____ **Weight:** _____ **How did you hear about our office?** _____

Address: _____

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

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

Pediatrician/Family MD: _____

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:** _____

At What Age Did the Child:

Respond to Sound _____ Follow an Object _____ Hold up Head _____ Sit Alone _____

Vocalize _____ Crawl _____ Stand _____ Walk _____ Sleep Through Night _____

CHEMICAL STRESSORS

During Pregnancy: (mother)

Smoke: ☐ No ☐ Yes
Drink Alcohol: ☐ No ☐ Yes
Supplements/Vitamins: ☐ No ☐ Yes
Drugs: ☐ No ☐ Yes
Medications: ☐ No ☐ Yes
Vaccinations: ☐ No ☐ Yes

Receive Ultrasounds: ☐ No ☐ Yes → How many: _____

Invasive Procedures (ex. Amniocentesis, CVS): ☐ No ☐ Yes→ Explain: _____

Feeding History:

Breast Fed: ☐ No ☐ Yes→ How Long? _____ Formula Fed: ☐ No ☐ Yes→ How Long? _____

Introduced: Solids at _____months Cow's Milk at _____months

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

Has Your Child had Antibiotics? ☐ No ☐ Yes→ How many courses? _____ Why? _____

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

Vaccine Reaction: ☐ No ☐ Yes→Explain _____

EMOTIONAL STRESSORS

Lactation Difficulties: ☐ No ☐ Yes→ Explain: _____

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

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

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

TRAUMATIC STRESSORS

Trauma During Birth:

Bruises: ☐ No ☐ Yes

Odd Shaped Head: ☐ No ☐ Yes

Stuck in Birth Canal: ☐ No ☐ Yes

Falls/Accidents during Pregnancy: ☐ No ☐ Yes

Surgeries: ☐ No ☐ Yes→ List: _____

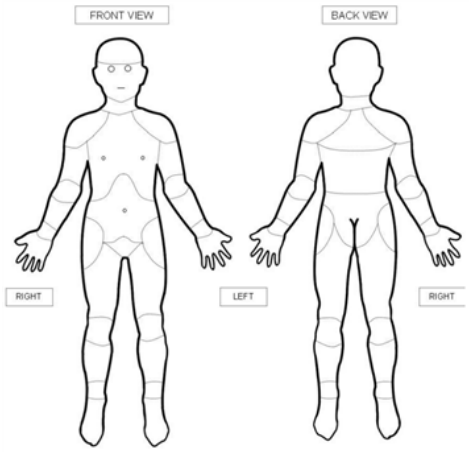
According to the National Safety Council, approximately 50% of children fall headfirst from a high place during their first year of life (bed, changing table, stairs, highchair, etc.)

Was this the case with your child? ☐ No ☐ Yes→ Explain: _____

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:***

☐ Hip Dysplasia	☐ Digestive Disorders	☐ Behavioral Problems	☐ Dizziness
☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD	☐ Fainting
☐ Arm Problems	☐ Shoulder Problems	☐ Ruptures/Hernia	☐ Seizures/Convulsions
☐ Leg Problems	☐ Reflux	☐ Heart Trouble	☐ Joint Problems
☐ Torticollis	☐ Jaundice	☐ Frequent Fevers	☐ Skull Deformity
☐ Constipation	☐ Diarrhea	☐ Colic	☐ Chronic Earaches
☐ Asthma	☐ Sinus Trouble	☐ Walking Trouble	☐ Anemia
☐ Colds/Flu	☐ Sleeping Problems	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed/couch	☐ Fall from crib	☐ Fall down stairs
☐ Car Accident	☐ Fall from highchair	☐ Concussion	☐ Fall from changing table

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:** _____