PEDIATRIC HISTORY FORM

Dear **New Patient,**

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: ______________________________ S.S.#: ______________________________

Address: ______________________________ City: ______________________________

State: ____________ Zip: ____________ Home Phone: ______________________________

Birth Date: _______/_________/ ________ Work Phone: ____________________ ____________________

Sex: __________ Weight: __________ Height: __________ Referred By: ______________________________

Names of Parents / Guardians: ______________________________

Purpose For Contacting Us?______________________________

Other Doctors Seen for this Condition:_______ N________Y , 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	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: ______________________________

Are You Satisfied with the Care Your Child has Received There ?________N _______ Y

Number of Doses of <u>Antibiotics</u> Your Child has Taken:

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

Number of Doses of <u>Other Prescription Medications</u> Your Child has Taken:

During the Past Six Months:_______ , Total During His / Her Lifetime: _______ List:______________________________

Vaccination History: ______________________________

Prenatal History:

Name of Obstetrician / Midwife: ______________________________

Complications During Pregnancy ? ________N _______ Y , List: ______________________________

Ultrasounds During Pregnancy ? _______N _______ Y, Number: ________

Medications During Pregnancy / Delivery ? _______ N _______ Y , List: ______________________________

Cigarette / Alcohol Use During Pregnancy: _______N _______ Y

Location of Birth: ______ Hospital _______ Birthing Center _______ Home

Birth Intervention: _______ Forceps________ Vacuum Extraction

______ Caesarian Section, Emergency or Planned?

Complications During Delivery ? _______N_______ Y, List: ____________

Genetic Disorders or Disabilities:_______N________Y, List: ____________

Birth Weight: _______ Birth Length:_______ APGAR Scores: _______

Feeding History:

Breast Fed: _________N _______ Y, How Long: ___________

Formula Fed: _______N _______ Y, How Long: ___________ Type:______

Introduced to Solids at:________ Months, Cows' Milk at ________ Months

Food / Juice Allergies or Intolerances:_______N _______ Y, 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
______Respond to Visual Stimuli
______Hold Head Up
______Sit Up
_______ Cross Crawl
_______ Stand Alone
_______ Walk Alone

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? _______ N ______Y

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

Has Your Child Ever Been Involved in a Car Accident? _______ N _______Y, List: ___________________________________

Has Your Child Been Seen on an Emergency Basis? _______ N _______ Y, List:___________________________________

Other Traumas Not Described Above? _______ N _______Y, List:____

Prior Surgery: _______N _______ Y, List:____

Menarche: _______N _______ Y, Age: ________

Childhood Diseases:

Chicken Pox	N / Y, Age_______	Mumps	N / Y, Age _______
Rubella	N / Y, Age_______	Whooping Cough	N / Y, Age _______
Measles	N / Y, Age_______	Other	N / Y, 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 an 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______________________________