

# ANDAN CHIROPRACTIC

## Pediatric Health History

Please bring your completed form to the receptionist.

(Office use: Comp # \_\_\_\_\_)

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Child's date of birth \_\_\_\_\_ Referred by \_\_\_\_\_

Health Insurance \_\_\_\_\_ Contract # \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber SSN \_\_\_\_\_ Child SSN \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Contract # \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber SSN \_\_\_\_\_ Child's Health Care Provider \_\_\_\_\_

Health Care Provider Address \_\_\_\_\_

Date of last Health Care Provider visit & reason \_\_\_\_\_

Previous DC (chiropractor) name and last visit \_\_\_\_\_

### **AUTHORIZATION OF CARE OF A MINOR**

Mother \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Stepfather \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Father \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Stepmother \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Are you a divorced/single parent **Y / N** Do you have sole custody **Y / N** (If parents are divorced and both are legal custodians, both must consent in writing to chiropractic care via a note, email, or our authorization form.)

**I hereby authorize and consent to the chiropractic evaluation and care of my child:**

Parent/Guardian signature \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Witness \_\_\_\_\_

Forms filled out by: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Current health concerns** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other care received for current concern(s), include medications \_\_\_\_\_

\_\_\_\_\_

Date of Onset \_\_\_/\_\_\_/\_\_\_ Onset was Sudden / Gradual / Associated with an event \_\_\_\_\_

Duration of problem (episode) \_\_\_\_\_ minutes / hours / days / months / years \_\_\_\_\_

Pattern of problem Constant / Intermittent / Occasional / Cyclical \_\_\_\_\_

Initiating factors \_\_\_\_\_

Aggravating factors \_\_\_\_\_

Relieving factors \_\_\_\_\_

Effects of problem on body function and daily activities \_\_\_\_\_

\_\_\_\_\_

Prior occurrence \_\_\_\_\_

**HISTORY OF BIRTH**

Hospital / Birthing Center / OBGYN / Certified Nurse Midwife / Home (Lay Midwife) \_\_\_\_\_

Duration of Gestation \_\_\_\_\_ weeks Duration of labor \_\_\_\_\_

Assisted birth **NO / YES:** forceps, vacuum extraction, c-section, induced labor \_\_\_\_\_

Medications delivered to mother during birth? **NO / YES:** list \_\_\_\_\_

Other Complications at birth: **NO / YES:** Explain \_\_\_\_\_

APGAR at birth: \_\_\_\_\_ After 5 minutes: \_\_\_\_\_ Birth weight: \_\_\_\_\_ length: \_\_\_\_\_

**GROWTH & DEVELOPMENT**

Was the infant alert and responsive within twelve hours of delivery? **YES / NO:** Explain \_\_\_\_\_

At what age did the child Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_

Vocalize \_\_\_\_\_ Sit alone \_\_\_\_\_ Teethe \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Run \_\_\_\_\_

Does current sleeping pattern seem normal to you **YES / NO** (ex. night terrors, sleep walking, difficulty sleeping)

Explain \_\_\_\_\_

Current Length/Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**CHEMICAL STRESSORS**

Was this baby breast-fed? **NO / YES:** How long? \_\_\_\_\_ Formula induced at age \_\_\_\_\_

Type of formula used \_\_\_\_\_ Introduction of cow's milk at age \_\_\_\_\_

Began solid foods at age \_\_\_\_\_ Age & type of commercial baby food intro \_\_\_\_\_

Food Intolerance? **NO / YES:** Type \_\_\_\_\_

Did the mother drink alcohol? **NO / YES:** amount \_\_\_\_\_ During pregnancy did the mother smoke? **NO / YES**

Any other smokers in the home? **NO / YES:** \_\_\_\_\_

Illness of the mother during pregnancy \_\_\_\_\_

Medications/drugs taken during pregnancy \_\_\_\_\_

Vitamin supplements taken during pregnancy \_\_\_\_\_

Exposures to ultrasound **NO / YES:** How many? Medical reason? \_\_\_\_\_

Any invasive procedures (amniocentesis, CVS) \_\_\_\_\_

Pets at home **NO / YES:** \_\_\_\_\_

Any vaccinations: **NO / YES:** Which ones and any reaction? \_\_\_\_\_

Antibiotics **NO / YES:** Explain \_\_\_\_\_

Any over-the-counter or prescription medications for the child, past or present \_\_\_\_\_

**PSYCHOSOCIAL STRESSORS**

Difficulties with Lactation NO / YES: \_\_\_\_\_

Behavior problems NO / YES: \_\_\_\_\_

Has this child ever received individual or family counseling? \_\_\_\_\_

**TRAUMATIC STRESSORS**

Traumas during pregnancy (falls, accidents) NO / YES: \_\_\_\_\_

Any evidence of birth trauma (ex bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, cord around neck, respiratory depression, ) \_\_\_\_\_

Falls from couches, beds, tables \_\_\_\_\_

Hospitalizations, surgeries, broken bones (include dates) \_\_\_\_\_

Athletics \_\_\_\_\_ age began \_\_\_\_\_

\_\_\_\_\_ age began \_\_\_\_\_

\_\_\_\_\_ age began \_\_\_\_\_

\_\_\_\_\_ age began \_\_\_\_\_

Weight of school backpack: \_\_\_\_\_ Approx. hours spent at play per week: \_\_\_\_\_

Average number of hours for TV a week: \_\_\_\_\_

**FAMILY HISTORY**

Significant health problems of parents and grandparents (cancer, diabetes, heart disease, etc) on the Mother's side \_\_\_\_\_

Father's side \_\_\_\_\_

With siblings \_\_\_\_\_

Has this child ever been a victim of physical or sexual abuse N / Y: Explain \_\_\_\_\_

Would you like a referral to a qualified professional regarding this concern? \_\_\_\_\_

**Thank you for completing this form.** Please indicate any other questions or concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ANDAN CHIROPRACTIC

## TERMS OF ACCEPTANCE

1. All first visit charges are payable at the time of service.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released. A copy may be made if necessary at the rate of \$40.00.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Andan Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Andan Chiropractic will be credited to my account upon receipt. I clearly understand and agree that I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

### Patient Privacy Notice

I have read your consent (privacy) policies and agree to the terms. The policies include disclosure of health information, marketing for Andan Chiropractic office usage, appointment reminders, and sign in sheet consent. Copies of Andan Chiropractic privacy policies are available. By signing this I acknowledge that I have been offered and/or have received a copy of the above policies.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Andan Chiropractic is authorized to share my health information and records with the following individuals:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_