

PEDIATRIC HISTORY FORM



PATIENT DEMOGRAPHICS

HR#: _____

Today's Date ____/____/____

Child's Name _____

Date of Birth ____/____/____ Age: ____

Birth Height: ____ Birth Weight: ____ Current Height: ____ Current Weight: ____

Address _____

City _____ State ____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB ____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____ City/State _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

Father's Social Security # ____ - ____ - ____ Mother's Social Security # ____ - ____ - ____

Other (please explain): _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ____ Wellness Check-up ____ Injury or Accident ____ Other

Please explain: _____

If your child is experiencing Pain/Discomfort please identify where and for how long

1. **When did the** Problem first begin? Date ____/____/____ __Unknown __Gradual __Sudden

2. **Ever had** this problem **before**? __ No __ Yes If yes, when? _____

3. Any **bowel or bladder** problems since this problem began?: If yes, describe: _____

4. Have you seen any **other doctors** for this problem? __ No __ Yes If yes, who? _____

5. How long ago? ____ Days ____ Weeks ____ Months ____ Years

6. What were the results of past treatment? _____

7. How is this problem **NOW?**: Rapidly Improving Improving Slowly About the Same
 Gradually Worsening On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | |

Allergies to _____

Other: _____

I understand that I am directly and fully responsible to Vitality Chiropractic and Family Wellness for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date

Doctor's Signature

Date

At Vitality Chiropractic and Family Wellness, we offer lab testing, food allergy testing, hair analysis, saliva testing and functional nutrition to optimize your health and wellness. Please indicate if you are interested in learning more about optimizing your health.

_____ Yes _____ No

Cancellation/ Broken Appointment Policy

Our commitment to your great chiropractic care begins with a defined schedule in which we have allotted specific amounts of time for you and other patient abased on your specific needs. With said, we understand that “life” happens and results in needed changes to our day to day schedule that may prevent us from keeping an appointment. We respectfully request at least **24 hour advanced notice** if you need to cancel an appointment. Giving us as much notice as possible ensures that someone else is able to take advantage of the time that was allotted to you.

An appointment that is cancelled with less than 24 hours’ notice or an appointment that is not canceled at all in which the patient fails to appear to is considered a broken appointment. Broken appointments delay the success of your treatment and the treatment of other patients. Therefore, any broken appointments will result in a **\$25.00 office fee**.

Thank you in advanced for your compliance without cancellation and broken appointment policies. Please know that all policies are in place to ensure a great chiropractic experience for you and your family. Again, we look forward to serving your every chiropractic need!

Please initial below that you read and understand the cancellation and broken appointment policy.

Initial Here: _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

I hereby authorize payment to be made directly to Vitality Chiropractic and Family Wellness, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Vitality Chiropractic and Family Wellness for any and all services I receive at this office.

Signature _____ Today’s

Date _____

Signature of Parent (for minor): _____ Today’s

Date _____

Thank you for being part of the Vitality Chiropractic Family.

We look forward to serving you.