Pediatric Information

Childs Name: _____ Parent/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: O Male O Female

Parents Email: _____

Insurance Card Holders Name & DOB: _____

Home: _____ Parents Work: _____ Parents Cell: _____

Is this a O Wellness visit, or is there a O Specific concern? _____

How did you hear about our office?: _____

Is your child receiving care from other health professionals? O Yes O No Name & Specialty : _____

Who is your family's primary care physician? _____

Has your child ever received chiropractic care? O Yes O No When? _____ Who? _____

Were you pleased with your care? O Yes O No

Do you have any concerns about seeing a chiropractor?: _____

Chiropractic Care and Consent to Evaluate a Minor

_____***My initials show:*** *I understand Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic evaluates the spine for vertebral subluxation and uses specific adjustments to assist the body in correcting the subluxation in order to restore the body's natural healing ability. We do not diagnose or treat any disease. (We only offer to diagnose and adjust vertebral subluxations). If in the course of the chiropractic examination non-chiropractic or unusual findings are present, you will be advised to seek the services or another health care provider.*

_____***My initials show:*** *I authorize Drs. James and/or Elizabeth Phillip to examine and administer care to my child as they deem appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.*

Insurance

_____***My initials show:*** *I understand and agree that if I have health and/or accident insurance, those policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. I understand and agree that I am personally responsible for payment for services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. It is understood and agreed that the amount paid to the doctor for x-rays is for examination and interpretation only and the actual films remain the property of this office, being on file where they may be viewed.*

_____ ***My initials show:*** *I authorize this health care facility to release all information related to the care my child receives, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.*

Notice of Privacy Practices

_____***My initials show:*** *I further acknowledge that Phillip Family Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Phillip Family Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of heath care operations of Phillip Family Chiropractic. The Notice of HIPAA Privacy Practices for Phillip Family Chiropractic is also provided on request at the main administration desk of this practice and on the website at www.phillipfamilychiro.com. This Notice of Privacy Practices also describes my rights and Phillip Family Chiropractic's duties with respect to my protected health information. Phillip Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Phillip Family Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.*

Parent-Guardian Signature: _____ **Date:** _____

Pediatric History

Current Health

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? O Suddenly O Gradually O Post-injury O Not Sure

Is this condition O Getting worse O Improving O Intermittent O Staying the same O Not Sure

Has your child ever had a similar condition? O Yes O No If yes, please explain: _____

Has your child been treated for this problem before? O Yes O No

If yes, please explain: _____

Does your child eat well/have a normal appetite? O Yes O No

Does your child have regular bowel movements? O Yes O No

Please list any drugs or medications your child is taking and why: _____

_____

Please list any vitamins/herbs/homeopathies/other your child is taking and why: _____

_____

Please list any allergies or food sensitivities your child has: _____

Has your child ever been checked for vertebral subluxations? O Yes O No O Don't know

Are there any other concerns you have about your child? _____

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the ***nervous system***. Your nervous system is surrounded and protected by the bones of the spine, called ***vertebrae***. Many of the common health challenges that adults experience have their origins during the developmental years, some starting at birth. Layers of damage to the spine and nervous system occur as a result of various physical traumas, chemical toxins and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system—a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

Physical Stress

- ☐ Birth Trauma
- ☐ Slips / Falls
- ☐ Car Accidents
- ☐ Tablet/Computer/Video Games
- ☐ TV
- ☐ Contact Sports
- ☐ Repetitive movements
- ☐ Poor Posture
- ☐ Heavy backpack
- ☐ Too much Sitting
- ☐ Bone fracture/s
- ☐ Surgery
- ☐ Other

Emotional Stress

- ☐ Family
- ☐ Friends (fitting in)
- ☐ School
- ☐ Homework
- ☐ Exams
- ☐ Fast paced life
- ☐ Sports
- ☐ Hold in feelings
- ☐ Quick tempered
- ☐ Perfectionist
- ☐ Procrastinator
- ☐ Sickness/loss of a loved one
- ☐ Self esteem
- ☐ Other

Chemical Stress

- ☐ Environment
- ☐ Second hand smoke
- ☐ Poor diet
- ☐ Caffeine (soda, coffee, energy drinks)
- ☐ Excessive sugar
- ☐ Processed foods
- ☐ Artificial sweeteners
- ☐ Conventional meat
- ☐ Antibiotics
- ☐ Prescription / over-the-counter drugs
- ☐ Vaccinations
- ☐ Fast food
- ☐ Microwaveable food
- ☐ Other

Pregnancy and Birth

Please list any drugs/medications taken during pregnancy: _____

Did the mother smoke during pregnancy? O Yes O No Consume alcohol? O Yes O No

Any exposure to ultrasound? O Yes O No Frequency: _____

Duration of gestation: _____ weeks / Was labor induced? O Yes O No

Birth Location: O Home O Birthing Center O Hospital / Attended by: O Midwife O Medical Doctor

Type of birth: O Normal Vaginal O Cesarean / Procedures used? O Forceps O Suction cup or Vacuum O Other

Drugs administered during labor? (anesthesia, epidural, etc.) Please describe _____

Presence at birth: O Normal O Cyanosis O Jaundice Birth weight: _____ Length: _____ APGAR scores: _____

Was the infant alert and responsive within 12 hours of birth? O Yes O No If No, explain: _____

Growth and Development

Were any developmental milestones abnormally delayed? O Yes O No

If yes, please explain _____

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

_____

Please list any major injuries, accidents, falls and/or fractures you child has sustained in his/her lifetime, including the year

_____

Is/was your child breastfed? O Yes O No If yes how long? _____

Hours sleeping / night? _____ Quality of sleep: O Good O Fair O Poor

Vaccinations: O Yes O No Has there been any reactions or behavior changes since vaccination? O Yes O No

If yes, please explain _____

Has the child received any antibiotics? O Yes O No

If yes, how many times and list reasons _____

Any difficulty with breastfeeding? O Yes O No If yes, please explain _____

Any difficulty with bonding? O Yes O No If yes, please explain _____

Any behavioral problems? O Yes O No If yes, please explain _____

Any night terrors, sleep walking or difficulty sleeping? O Yes O No If yes please explain _____

Does your child seem normal for their age? O Yes O No If no please explain _____

Health History P = Past, / C = Current

P/C	P/C	P/C	P/C
☐ ☐ Asthma	☐ ☐ Allergies	☐ ☐ Back Pain	☐ ☐ Bed Wetting
☐ ☐ Respiratory Tract Infections	☐ ☐ Food Sensitivities	☐ ☐ Growing Pains	☐ ☐ Sleep Problems
☐ ☐ Sinus Problems	☐ ☐ Digestive Problems	☐ ☐ Scoliosis	☐ ☐ Night Terrors
☐ ☐ Ear Infections	☐ ☐ Frequent Diarrhea	☐ ☐ Red/Swollen/Painful Joint	☐ ☐ Tip Toe Walking
☐ ☐ Tonsillitis	☐ ☐ Constipation	☐ ☐ Colic	☐ ☐ Sensory Processing Issues
☐ ☐ Strept Throat	☐ ☐ Flatulence	☐ ☐ Frequent Crying Spells	☐ ☐ Seizures
☐ ☐ Frequent Colds	☐ ☐ Headaches/Migraines	☐ ☐ Failure to Thrive/Slow weight Gain	☐ ☐ Tremors / Shaking
☐ ☐ Recurrent Fevers	☐ ☐ Neck Pain	☐ ☐ Slow or Absent Reflexes	☐ ☐ ADD / ADHD
☐ ☐ Eczema	☐ ☐ Torticollis/Head Tilt	☐ ☐ Asymmetrical Crawling or Gait	☐ ☐ Autism / PPD
☐ ☐ Rashes	☐ ☐ Trouble Feeding on One Side	☐ ☐ Weight Challenges	☐ ☐ Anxiety