PEDIATRIC HEALTH HISTORY (Ages 6-12)

Child's Name_____ DOB:_____ Age:___ □ Male □ Female

Address _____City_____State_____Zip_____

Height_____ Weight_____ Grade_____ # of Siblings_____ Ages_____

Mother_____Cell#_____Father_____Cell#_____

Home Phone _____Mothers / Fathers Email_____

Pediatrician/Family MD _____ Office Location: _____

Who is responsible for this account? □ Mother SS#_____-_____-_____ □ Father SS#_____-_____-_____

Whom may we thank for referring you?_____ □ Phone Book □ Website □ Sign □ Other_____

Welcome to our office. We are honored that you have chosen our office to serve your family. Please know that we will care for your child with the greatest respect and treat them as if they are our own.

Why did you decided to have your child evaluated at our office?

- He/She is continuing ongoing care from another chiropractor.
- I recently had my spine and nervous system checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He/She has a specific condition and I've learned that chiropractic may be able to help.
- I'm interested in improving my child's overall health and wellness.
- Other:_____

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve for this child. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Enhanced Emotional Well-Being	Better Concentration
Stronger Immune System	Other_____	

Current Concern (if any): *(circle, highlight or write where applicable)*

- Check here if your child is here for a wellness check-up and skip to the next section (Pregnancy & Birth History)

Primary Concern_____

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM Bed It Varies It's getting: Better Worse No Change

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____

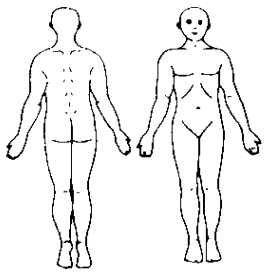
h. Has your child seen anyone for this? Yes No Who?_____

i. What were the results of the treatment?_____

j. Any medications taken for this problem?_____

k. How does this affect their life? *(circle/write)* poor school performance / irritability / interrupted sleep / fatigued / restricted daily activities / hinders social activities / other_____

Mark areas below



Other Concerns *(briefly describe)*_____

Continued on back...

Pregnancy & Birth History: Please tell us about your pregnancy and birth experience *(circle, highlight or write)*

1) How would you describe this pregnancy overall? Good Great Stressful (explain)_____
2) Medications during pregnancy? Yes No Why?_____
3) Ultrasounds during pregnancy? Yes No # & Why?_____
4) Complications during pregnancy? Yes No What? (BP, diabetes, etc)_____
5) Was your child at any time during your pregnancy in an intra-uterine constraining position? Yes No Unsure
   If yes, please describe: Breech Transverse Frank Face/Brow presentation Other:_____
6) Place of birth: Home Birthing Center Hospital Other_____
7) Birth Attendant(s): Doula Midwife OB-Gyn Name(s)_____
8) Was labor induced? Yes No Why?_____ Was anesthesia used? Yes No
9) How long was labor and delivery? _____hours What week did you give birth?_____wks
10) Type of Birth: Vaginal C-Section (Planned) C-Section (Emergency)
11) Were any of the following interventions used for delivery? Dr. Assisted Pulling Forceps Vacuum Extraction N/A
12) Any Birth Trauma? (bruising/purple markings on head/dislocations/etc)_____
13) Any: Jaundice (Yellow) / Cyanosis (Blue) / Congenital Anomalies/Defects:_____

Infant History (0-24 months): *(circle, highlight or write where applicable)*

1) Did you breast feed your child? Yes, exclusively Yes, formula supplemented No
   If yes, for how long? _____ Weeks/months Any problems with formula if you used them? Yes No
2) At what age did your child: Hold head up_____ Laugh_____ Roll over (front to back)_____
   Sit alone_____ Crawl_____ Stand_____ Walk (unassisted)_____
3) Any developmental challenges? Yes No Explain:_____
4) Did your child have at least 1 bowel movement per day? Yes No If no, how often_____
5) Did you choose to vaccinate your child? Yes No If yes, were they on a Traditional or Modified Schedule?
   Any adverse reactions from any vaccinations? Yes No_____
6) Any use of drugs or antibiotics? Yes No What & Why?_____

Health History: *(circle, highlight or write where applicable any **past or present** health challenges)*

Asthma	Sinus Problems	Allergies_____	
Frequent Colds	Ear Infections / Tubes	Headaches/Migraines	Seizures
Fainting	Dizziness	Behavioral Challenges	ADD/ADHD
Neck Pain	Arm Pain	Back Pain	Leg Pain
Scoliosis	Poor Posture	Muscle Pain	Growing Pains
Colic	Constipation	Diarrhea	Digestive Disorder
Reflux	Stomach Aches	Bladder Problems	Bed Wetting
Poor Appetite	Anemia	SI Problems_____	
Heart Condition	Night Terrors	Learning Disorders_____	
Sleeping Trouble	Tantrums	ASD (type)_____	

Falls over 3 ft (high chair, changing station, counter, playground)_____

Overall Health History: *(circle, highlight or write where applicable)*

1) List any allergies: No known / _____
2) Vitamins/Herbs/Minerals/etc: None / _____
3) Current medications: None / _____
4) Does your child follow a special diet: Yes No _____
5) Does your child consume: *(circle)* Caffeine Processed Foods Artificial Sweeteners Soda
   Fast Food Fresh Fruits Fresh Vegetables Sugar
6) How many hrs/day does your child spend in front of a tv, computer or video game?_____
7) Please rate the following for your child: (P) Poor, (G) Good or (E) Excellent
   Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Continued on next page...

Spinal Health: (circle, highlight or write where applicable)

1) Has your child ever had their vision checked by an optometrist before? Yes No
2) Has your child ever had their teeth checked before? Yes No
3) Has your child ever had their spine and nervous system checked by a doctor of chiropractic before? Yes No
   Who?_____Date of last visit?_____Reason for ending care?_____
4) Have they ever had spinal x-rays taken? Yes No When?_____ Were they standing? Yes No
5) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.
   Does your child ever feel the need to twist, stretch or crack their neck or spine? Yes No
6) Poor posture leads to poor health and often indicates spinal problems. Please rate your child's posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
7) Stress can cause or accelerate spinal damage. Rate your child's stress level for the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High

Injuries/Surgeries: *(Date & Description)*

Auto Accidents: N/A / _____

Recreational Accidents: N/A / _____

Fractures / Dislocations: N/A / _____

Surgeries: N/A / _____

Family History:

Does anyone in your family suffer with any of the following conditions? *(Please circle or highlight Father &/or Mother)*

F M Heart Disease F M Strokes F M Cancer (types):_____
F M High BP F M Thyroid F M Neurological - Parkinson's, ALS, MS, other_____
F M Diabetes F M Asthma F M Other_____

Would you like to receive our health and wellness newsletter (1-2 times per month via email)? Yes No
(Topics include: diet, exercise, stress management, women's and children's health, wellness topics, etc.)

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of?_____

Fees & Care Plans:

Initial Exam	$80
X-rays	$70/set
Adjustments	$40
Re-Exam	$50

On your second visit, Dr. Sullivan will review the results of your child's exam and go over their care plan. We will also review the financial responsibilities regarding care. If you have insurance, please read the section below.

Insurance: We used to be 'in network' with many insurance companies; however, we found being 'out of network' offered our patients *better* coverage and *fewer* restrictions. Currently we are 'in network' with BC/BS & Medicare. We are considered 'out of network' for all others. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit when the doctor reviews your care plan.

MEDICAID – Currently Medicaid DOES NOT offer ANY chiropractic benefits. The fees listed above will be your full financial responsibility if you have Medicaid or any Medicaid type policy.

Consent to evaluate and treat a minor:

I, _____ being the parent or legal guardian of _____ have filled out the above information to be accurate to the best of my knowledge. After careful consideration I do hereby request and authorize a complete evaluation including 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.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care my child receives whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years.

The above information is true and accurate to the best of my knowledge.

Parent or Legal Guardian's Name	Parent or Legal Guardian's Signature	Date	Dr. Initials