PEDIATRIC HEALTH HISTORY (0-24 month)

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

Address _____City_____State_____Zip_____

Height/Length_____ Weight_____ # 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 baby with the greatest respect and treat them as if they are our own.

Why did you decided to have your baby 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 baby 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 baby'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 your baby. *(Circle as many goals as you wish)*

Better Sleep	Freedom from Discomfort	Easier Breathing
Improved Nutrition & Diet	Improved Breastfeeding	Eliminate Medications
Improved Overall Health	Stronger Immune System	Improved Bowel Function

Other_____

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

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

Baby's Primary Concern_____

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

b. Condition came on: Sudden Gradual How:_____

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

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

e. What makes it better?_____ What makes it worse?_____

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

g. What were the results of the treatment?_____

h. Any medications taken for this concern?_____

Other Concerns (if any) *(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) Was this your first birth? Yes No How many other births have you had?_____
3) Medications during pregnancy? Yes No Why?_____
4) Ultrasounds during pregnancy? Yes No # & Why?_____
5) Complications during pregnancy? Yes No What? (BP, diabetes, etc)_____
6) 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:_____
7) Place of birth: Home Birthing Center Hospital Other_____
8) Birth Attendant(s): Doula Midwife OB-Gyn Name(s)_____
9) Was labor induced? Yes No Why?_____ Was anesthesia used? Yes No
10) How long was labor and delivery? _____hours What week did you give birth?_____wks
11) Type of Birth: Vaginal C-Section (Planned) C-Section (Emergency)
12) Were any of the following interventions used for delivery? Dr. Assisted Pulling Forceps Vacuum Extraction N/A
13) Any Birth Trauma? (bruising/purple markings on head/dislocations/etc)_____
14) Any: Jaundice (Yellow) / Cyanosis (Blue) / Congenital Anomalies/Defects:_____
15) Birth Weight_____ Birth Length_____ APGAR score?_____(out of 10) Unknown
16) Was your baby taken away immediately after birth? Yes No Why?_____
17) Was any medication given to your baby after birth? Yes No Why?_____

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

1) Is your baby currently being breast fed? Yes, exclusively Yes, formula supplemented No
   If no, how long was your baby breast fed? _____ Weeks/months
2) Does your baby prefer one breast over the other? Yes No Preferred Breast? Left / Right
3) Did/do you feed your baby formula? Yes No Any problems?_____
4) Does your baby frequently spit up? Yes No How often?_____
5) Is your baby eating solid foods? Yes No What kinds?_____
6) Does your baby follow a special diet? Yes No _____
7) Does your baby show sensitivity to any foods (either your diet or their own)? Yes No _____
8) Does your baby cry often Yes No If yes, approximately how many hours per day? _____
9) Does your baby have a lot of intestinal gas? Yes No
10) Does your baby have at least 1 bowel movement per day? Yes No If no, how often_____
11) Does your baby sleep well? Yes No How often do they wake up during the night?_____
    Do they have a preferred sleeping position? Yes No _____
12) Does your baby have a preferred head position? (leans or turns one way) Yes No_____
13) Does your baby frequently arch their head and neck backwards? Yes No
14) At what age did your baby: Hold head up_____ Laugh_____ Roll over (front to back)_____
    Sit alone_____ Crawl_____ Stand_____ Walk (unassisted)_____
15) Any developmental challenges? Yes No Explain:_____
16) Did you choose to vaccinate your baby? Yes No If yes, are they on a Traditional or Modified Schedule?
    Any adverse reactions from vaccinations? Yes No_____
17) 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	Seizures	Heart Condition
Colic	Constipation	Diarrhea	Digestive Disorder
Reflux	Stomach Aches	Poor Appetite	Sleeping Trouble

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

Continued on next page...

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) How many hrs/day does your baby spend in front of a tv or computer?_____
5) Please rate the following for your baby: (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

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

1) Has your baby 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?_____
2) Have they ever had spinal x-rays taken? Yes No When?_____

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_____

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

Fees & Care Plans:

Initial Exam	$95 - $125
Adjustments	$45 - $60
Re-Exam	$60

On your second visit, Dr. Sullivan will review the results of your baby'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 most of our patients' *better* coverage and *fewer* restrictions. Currently we are ***'in network'*** with **Blue Cross Blue Shield (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.

BC/BS – Most BC/BS plans have coverage for the initial exam in a chiropractic office for children however visits after that are usually considered *'not medically necessary'* per their guidelines and wouldn't be covered. BC/BS policies only cover care they consider to be '*medically necessary'*. Examples of this are musculoskeletal complaints like neck pain, headaches, back pain, sciatica and sometimes torticollis in infants & children.

MEDICAID – Medicaid **DOES NOT** offer ANY chiropractic benefits. Fees listed above will be your financial responsibility.

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