

PEDIATRIC HEALTH HISTORY (Teenager)



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)*

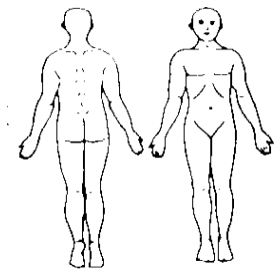
- | | | |
|--|--|--|
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Better Sleep | <input type="checkbox"/> Freedom from Pain |
| <input type="checkbox"/> Easier Breathing | <input type="checkbox"/> Improved Posture | <input type="checkbox"/> Improved Nutrition & Diet |
| <input type="checkbox"/> Improved Coordination | <input type="checkbox"/> Eliminate Medications | <input type="checkbox"/> Improved Overall Health |
| <input type="checkbox"/> Better Sports Performance | <input type="checkbox"/> Enhanced Emotional Well-Being | <input type="checkbox"/> Better Concentration |
| <input type="checkbox"/> Stronger Immune System | <input type="checkbox"/> 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 _____ **Mark areas below**
- 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 _____



Other Concerns *(briefly describe)* _____

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) Any complications during pregnancy? Yes No What? (BP, diabetes, etc)_____
- 3) Was your child at any time during your pregnancy in an intra-uterine constricting position? Yes No Unsure
If yes, please describe: Breech Transverse Frank Face/Brow presentation Other:_____
- 4) Place of birth: Home Birthing Center Hospital Other_____
- 5) Birth Attendant(s): Doula Midwife OB-Gyn Name(s)_____
- 6) Was labor induced? Yes No Why?_____ Was anesthesia used? Yes No
- 7) Type of Birth: Vaginal C-Section (Planned) C-Section (Emergency)
- 8) Were any of the following interventions used for delivery? Dr. Assisted Pulling Forceps Vacuum Extraction N/A
- 9) Any Birth Trauma? (bruising/purple markings on head/dislocations/etc)_____
- 10) Any: Jaundice (Yellow) / Cyanosis (Blue) / Congenital Anomalies/Defects:_____

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 Problems	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)	_____

- 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) Please list any sports your child plays:_____
- 7) How many hrs/day does your child spend: watching tv?_____ Playing computer/video games?_____
- 8) 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

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 spine and nervous system checked by a doctor of chiropractic before? Yes No
Who?_____ Date of last visit?_____ Reason for ending care?_____
- 3) Have they ever had spinal x-rays taken? Yes No When?_____ Were they standing? Yes No
- 4) 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
- 5) 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
- 6) 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

Continued on next page...

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 child'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
X-rays	\$75/set (typically 2 sets with initial start up)
Adjustments	\$45 - \$60
Re-Exam	\$60

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 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 might not be considered '*medically necessary*' per their guidelines and wouldn't be covered unless they have a musculoskeletal complaint like neck pain, headaches, back pain, sciatica, etc. BC/BS policies only cover care they consider to be '*medically necessary*'.

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

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

_____	_____	_____
Patient Signature	Date	Dr. Initials

Continued on back...

ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

- 1) **Pain Intensity:** 0-----1-----2-----3-----4
 None Mild Moderate Severe Unbearable

- 2) **Frequency of Pain:** 0-----1-----2-----3-----4
 None 25% of the day 50% of the day 75% of the day Constant

- 3) **Lifting:** 0-----1-----2-----3-----4
 No Pain w/
Heavy Weight Increased Pain
w/ Heavy Wt. Increased Pain
w/ Moderate Wt. Increased Pain
w/ Light Wt. Increased Pain
w/ Any Wt.

- 4) **Walking:** 0-----1-----2-----3-----4
 No Pain w/
Any Distance Increased Pain
After 1 Mile Increased Pain
After 1/2 Mile Increased Pain
After 1/4 Mile Increased Pain
w/ Any Distance

- 5) **Standing:** 0-----1-----2-----3-----4
 No Pain After
Several Hours Increased Pain
After Several Hours Increased Pain
After 1 Hour Increased Pain
After 1/2 Hour Increased Pain
w/ Any Standing

- 6) **Travel:** 0-----1-----2-----3-----4
 (Driving)
No Pain on
Long Trips Mild Pain on
Long Trips Moderate Pain
on Long Trips Moderate Pain
on Short Trips Severe Pain on
Short Trips

- 7) **Work:** 0-----1-----2-----3-----4
 Do Usual Work
+ Unlimited Extra Do Usual Work
But No Extra Can do 50%
of Usual Work Can do 25%
of Usual Work Cannot
Work

- 8) **Sleeping:** 0-----1-----2-----3-----4
 Perfect Sleep Mildly Disturbed Moderately Disturbed Severely Disturbed Totally Disturbed

- 9) **Personal Care:** 0-----1-----2-----3-----4
 (Washing,
Dressing, etc.) No Pain Mild Pain Moderate Pain Severe Pain Unbearable Pain

- 10) **Recreation:** 0-----1-----2-----3-----4
 Can do All
Activities Can do Most
Activities Can do Some
Activities Can do Few
Activities Cannot do Any
Activities

Patient Signature: _____ Date: _____ Score: _____