

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)*

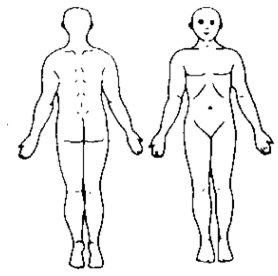
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|---------------------------|-------------------------------|---------------------------|
| More Energy | Better Sleep | Freedom from Pain |
| Easier Breathing | Improved Posture | Improved Nutrition & Diet |
| Improved Coordination | Eliminate Medications | 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 _____ **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) 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 constricting 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 _____

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
 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. We can work with most insurance companies to submit claims electronically on your behalf. Currently we are '**in network**' with **Medicare** and 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.

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