# PEDIATRIC HEALTH HISTORY (Ages 2-5)

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)*

| | | |
|---|---|---|
| Better Sleep | Freedom from discomfort | Easier Breathing |
| Improved Nutrition & Diet | Improved Coordination | Eliminate Medications |
| Improved Overall Health | Enhanced Emotional Well-Being | 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. Condition came on: Sudden Gradual How:_____

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

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

e. What makes it better?_____

f. What makes it worse?_____

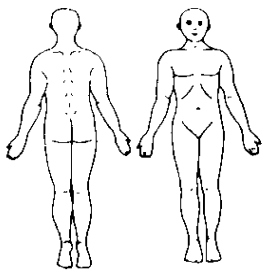
g. Has your child seen anyone for this? Yes No Who?_____

h. What were the results of the treatment?_____

i. Any medications taken for this problem?_____

j. 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)*_____

_____

_____

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**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 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?_____ Were they standing? Yes No
3) 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
4) 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 |
|---|---|---|---|

**Continued on back...**

**BC FAMILY CHIROPRACTIC, PC**
**365 HARRY L. DRIVE**
**JOHNSON CITY, NY 13790**
**(607) 754-5900 / (607) 217-5257 (fax)**

# Informed Consent

We encourage and support a **shared decision making process** regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full.

**Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation. A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and/or radiological examination (x-rays).

The **chiropractic adjustment** is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some **risks and limitations** of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care.**

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BC FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC.**

| _____ | _____ | _____ |
|---|---|---|
| **Patient Name** | **Patient Signature** | **Date** |

**PARENTAL CONSENT FOR MINOR PATIENT**:

**Patient Name: _____ age: ____ DOB: _____ Relationship to patient_____**

| _____ _____ | _____ | _____ |
|---|---|---|
| **Parent / Legal Guardian Name** | **Parent / Guardian Signature** | **Date** |

**CONSENT TO TREAT WITHOUT A PARENT / GUARDIAN PRESENT:**

**In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.**

| _____ | _____ | _____ |
|---|---|---|
| **Parent / Legal Guardian Name** | **Parent / Guardian Signature** | **Date** |