VERTICAL CHIROPRACTIC

CHILD BY DESIGN

Child Name: _____

Parent/Guardian: _____

PEDIATRIC DEVELOPMENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Age: _____ Birth Date: _____/_____/_____ Gender: M F Weight: ____lbs. Height _____in.

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Who can we thank for referring you here today? _____

HEALTH CONCERNS

Reason for pursuing care: ☐ Wellness Check-up ☐ Injury / Accident ☐ Other Problem: _____

Other doctors seen for this condition? ☐ Yes ☐ No What are doctor's names and prior treatment:

_____

List any other health problems: _____

Family history: _____

Check any of the following conditions that currently apply:

___ Ear infections	___ Scoliosis	___ Chronic colds	___ Headaches
___ Allergies	___ Digestive issues	___ ADHD / ADD	___ Recurring fevers
___ Colic	___ Growing / back pains	___ Bed wetting	___ Temper tantrums
___ Seizures	___ Asthma	___ Car accidents:	___ Walking problems
___ Other: _____		When? _____	

Previous chiropractic care? ☐ Yes ☐ No Last visit:_____

Name of pediatrician: _____ Last visit: _____

# of doses of antibiotics your child has taken: Past 6 months _____ Total lifetime _____

Present prescription drugs / dosage: _____

Past prescription drugs / dosage: _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.): _____

Food / juice allergies or intolerances? ☐ Yes ☐ No List: _____

BIRTH HISTORY

Complications during pregnancy / delivery? ☐ Yes ☐ No Explain: _____

Birth Intervention? Forceps Vacuum extraction Caesarian section

Genetic disorders / disabilities? ☐ Yes ☐ No List: _____

DEVELOPMENTAL HISTORY

At what age was your child able to:

_____ Respond to stimuli	_____ Cross crawl	_____ Stand alone
_____ Respond to visual stimuli	_____ Hold head up	_____ Walk alone
_____ Sit up		

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did you child have a fall similar to what was described above? ☐ Yes ☐ No

Explain: _____

Has your child been involved in any sports? ☐ Yes ☐ No List: _____

Please list all past broken bones, surgeries or hospitalizations: _____

_____

Other traumas not listed: _____

Is there anything else you would like us to know about your child?

_____

ACKNOWLEGMENTS: Please read each statement and initial your agreement on the left.

Insurance Information

_____ I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Privacy Policy

_____ I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

_____ Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.

_____ _____

Parent / Guardian Signature Date Doctor Signature Date

FAMILY HEALTH HISTORY

Your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

Please check off any of the conditions below that you and your family have or have had in the past:
*** Write C if current issue or P if past issue**

	Patient	Sibling(s)	Mother	Father	Other
Asthma / Allergies					
Arthritis					
TMJ					
Acid Reflux					
Epilepsy / Seizure					
Ulcers					
Dizziness					
Headaches					
Vertigo					
Neurological Problem					
Menstrual Irregularity					
Nausea					
Lupus					
Fatigue					
Numbness					
Ear Infection					
Sciatica					
Heart Condition					
Migraines					
Thyroid Problem					
Kidney Problem					
Liver Disease					
Fainting					
Disc Problem					
Neck / Back Pain					
Irritable Bowel					
Digestive Problem					

Circle any of the following conditions your child currently has or in the past:

STROKE CANCER HEART DISEASE SEIZURES SPINAL FRACTURE SCOLIOSIS DIABETES

RHEUMATOID ARTHRITIS AIDS/HIV GENETIC DISEASE OTHER _____

_____ _____

Parent / Guardian Signature Date Doctor Signature Date