



PEDIATRIC HISTORY FORM FOR CHILDREN AGES 6-17 YEARS OLD

Today's Date ____/____/____ How did you hear about our office: _____
(Google, Facebook, friend, patient etc.)

PATIENT DEMOGRAPHICS:

Child's Name _____

Date of Birth ____/____/____ Age: ____

Birth Height: ____ Birth Weight: ____ Current Height: ____ Current Weight: ____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB ____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Family e-mail: _____

(Our office uses e-mail to inform you of office closures, changes in hours due to weather, vacation, etc.)

Pediatrician/Family MD _____ City/State _____

Last Visit: ____/____/____ Reason for visit: _____

REASON FOR CONTACTING OUR OFFICE:

Please identify the condition(s) that brought your child to our office: _____

If your child is experiencing Pain/Discomfort please identify where and for how long

1. When did the Problem first begin? Date ____/____/____ ____ Unknown ____ Gradual ____ Sudden

2. Ever had this problem before? No Yes If yes, when? _____

3. Any bowel or bladder problems since this problem began?: No Yes If Yes, explain: _____

4. Have you seen any other doctors for this problem? No Yes If yes, who?

5. How is this problem NOW?: Rapidly Improving Improving Slowly About the Same
 Gradually Worsening On & Off

6. Please list any medication(s) taken for this problem: _____

7. Has your child ever sustained an injury playing organized sports? No Yes If yes; please explain:

8. Has your child ever sustained an injury in an auto accident? No Yes If yes; please explain:

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | |

Allergies: _____

Medications: _____

Other: _____

9. Has your child been prescribed antibiotics in the last 6 months: No Yes

10. Have you chosen to have your child vaccinated? No Yes If Yes, have you noticed any side effects or changes after vaccinations? _____

11. Any other information, not mentioned above, that you would like the doctor to know about:

For patients ages 14-17, please complete the table below

ACTIVITIES of DAILY LIVING ASSESSMENT

Rate your current difficulties with Daily Activities,

CHECK THE APPROPRIATE BOX that most closely describes your current degree of difficulty:

Activities	#1 No difficulty	#2 Some pain	#3 Difficult/ Marked pain	#4 Painful but need help	#5 Unable to perform
Bathing / Showering					
Dressing					
Shaving					
Washing hair					
Household chores					
Standing					
Sitting					
Walking					
Bending-forward/backwards					
Twisting – right/left					
Leaning – forward/backward					
Climbing stairs					
Exercising					
Driving a car					
Riding in car for long distances					
Trouble using computer					
Trouble participating in athletic activities					
Carrying backpack					

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Parent Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Parent Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Check box if applicable:

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date

Doctor's Signature

Date



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I authorize **Parent Chiropractic Center** to speak to _____,
(Relationship) _____ regarding any treatments/concerns related to my healthcare.

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

I have read and fully understand the above statements and accept chiropractic care on this basis.

Signature: _____ date: _____



Billing, Insurance and Financial Policies

At Parent Chiropractic Center we are committed to providing you and your family with the best chiropractic care possible in a caring environment, and have established our financial and health insurance policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you elect to participate in our Chiropractic Care Plan Agreement that include annual or monthly payments. Details of these plans will be discussed during your Report of Findings appointments.

Health Insurance: We accept and participate in many plans. Our office is happy to file insurance for you, however, it is important to know that all insurance companies state the disclaimer: “**VERIFICATION IS NOT A GUARANTEE OF PAYMENT.**” We verify insurance as a courtesy; this is not a guarantee of benefits. We ask that you contact your insurance company to verify your chiropractic coverage as well. It is your responsibility to thoroughly understand your insurance benefits. You are ultimately responsible for any co-payments, deductibles, and portion of care that is not covered by your health insurance. We strongly advise you to maintain contact with your insurer in order to confirm coverage and benefits. Following this procedure will help to prevent problems with billing and reimbursement. Should your insurance coverage change, it is your responsibility to inform us immediately. You will be responsible for any balance due that insurance does not pay for.

Medicare patients – we are providers for Medicare, however, Medicare does not cover the initial exam, x-rays, or scans for Medicare patients. These fees are the responsibility of the patient. Please call our office for rates and we will be happy to help you with any questions you may have.

Past Due Accounts - We make every effort to avoid using a collection agency to settle an account. However, In the event that an account is over 90 days past due, and all attempts to collect the debt have gone unanswered, you will be responsible for the outstanding amount due in addition to any fees that the collection agency charges to collect the outstanding debt. There is a \$25.00 fee in the event of a returned check from the bank due to insufficient funds.

Release of Medical Records – I give permission for Dr. Parent to request medical information from other medical facilities that may help the doctor to accurately assess and treat my condition.

HIPPA / Privacy Practices – I acknowledge that I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Our office will use e-mail to inform you of any changes in our office hours, closings, education etc. In the event of a missed appointment, we will call the phone number provided to us.

I have read and understand each of the above mentioned office policies:

Patient/Guardian signature

Date