PARENT CHIROPRACTIC CENTER

# PEDIATRIC HISTORY FORM – FOR CHILDREN (AGES BIRTH-5 YEARS OLD)

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

## PATIENT DEMPGRAPHICS:

Childs 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. Have you seen any **other doctors** for this problem? ☐ No ☐ Yes If yes, who? _____
3. How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same
   ☐ Gradually Worsening ☐ On & Off

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

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

☐ Allergies: _____

☐ Medications: _____

☐ Other: _____

4. Has your child been prescribed antibiotics in the last 6 months: ☐ No ☐ Yes
5. Have you chosen to have your child vaccinated? ☐ No ☐ Yes If Yes, have you noticed any side effects or changes after vaccinations? _____
6. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes If yes; please explain:

_____

_____

**PRENATAL HISTORY:**

Name of Obstetrician/Midwife: _____

Complications during Pregnancy? ☐ No ☐ Yes Explain_____

Ultrasounds during Pregnancy? ☐ No ☐ Yes How many? _____

Medications during Pregnancy / Delivery ☐ No ☐ Yes List_____

Cigarette / Alcohol use during Pregnancy ☐ No ☐ Yes

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

Vaccines/Supplements taken during Pregnancy _____

Birth Intervention ☐ None ☐ Forceps ☐ Vacuum extraction ☐ Caesarian section – Emergency or Planned section

Complications during delivery? ☐ No ☐ Yes Explain _____

Genetic disorders or disabilities? ☐ No ☐ Yes Explain _____

## FEEDING HISTORY:

Breast fed: ☐ No ☐ Yes, how long: _____ Formula fed ☐ No ☐ Yes, how long: _____

Introduced solids at _____ months Cow's milk at _____ months

Food / Juice Allergies or Intolerances: ☐ No ☐ Yes, List _____

## DEVELOPMENTAL HISTORY:

During the following milestones your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spine & nerve interference)

At what age was your child able to:

Respond to sound _____ Crawling _____ Respond to Visual stimuli _____

Stand Alone _____ 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, flight of stairs, etc.) Was this the case with your child? ☐ No ☐ Yes

Has your child been seen on an Emergency basis? ☐ No ☐ Yes _____

Any other traumas not listed above? ☐ No ☐ Yes _____

Any surgeries? ☐ No ☐ Yes _____

Any other information that you would like the doctor to be aware of? _____

_____

_____

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