INFANT HEALTH HISTORY (0-4 years)

We are excited that you have chosen Brecksville Physical Medicine to assist in the health and wellness needs of you and your family. Let us know if there is anything we can do to make you more comfortable. Please complete this form as much as possible so that we can provide the best possible care for your family.

Child's Name: _____

Home address: _____ City, State, Zip: _____

Age: _____ Date of Birth: ____/____/____ Male ☐ Female ☐ Weight: _____ Height: _____

Father's Name: _____ Mother's Name: _____

Father's Cell: _____ Mother's Cell: _____

Father's Work: _____ Mother's Work: _____

Home Phone: _____ Email address: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

REASONS FOR SEEKING CHIROPRACTIC CARE:

At Brecksville Physical Medicine, our goals are to address the issues that brought you and your child into the office and offer the best care to improve their health and quality of life.

Please briefly describe the main concern that you would like us to address:

Child's Current Problem: _____ When did it begin? _____

How often does it occur? _____ What activities are affected? _____

Other doctors seen for this condition☐ Medical Doctor: _____☐ Other: _____

X-rays taken: ☐ Yes ☐ No Special tests done: ☐ Yes ☐ No

Diagnosis: _____ What was done? _____

Has your child ever had chiropractic care? ☐ Yes ☐ No Name of D.C. _____

How long under care? _____ Date of last visit: _____

Why was care stopped? _____

Have any of the following occurred? (Check all that apply)

- ☐ Frequent crying spells
- ☐ Trouble sleeping
- ☐ Colic
- ☐ Reflux
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Repeated infections/colds
- ☐ Frequent fevers
- ☐ Frequent ear infections
- ☐ Reaction to vaccines
- ☐ Weight loss/gain
- ☐ Tonsillitis
- ☐ Stomach pains
- ☐ Hyperactivity/Autism
- ☐ Asthma
- ☐ Bed wetting
- ☐ Allergies
- ☐ Learning difficulties
- ☐ Neck problems
- ☐ Arm problems
- ☐ Leg/Knee problems
- ☐ Backaches
- ☐ Joint problems
- ☐ Poor posture
- ☐ Scoliosis
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Sinus Trouble
- ☐ Trouble walking
- ☐ Broken Bones
- ☐ Anemia
- ☐ Digestive Disorders
- ☐ Poor Appetite

Other (please explain): _____

Allergies to _____

- ☐ Fall from changing table
- ☐ Fall out of crib
- ☐ Tumble down stairs
- ☐ Involvement in car accident
- ☐ Fall from tree
- ☐ Sports accident
- ☐ Fall on playground
- ☐ Fall off bicycle
- ☐ Fall from baby walker
- ☐ Fall from high-chair
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall down stairs
- ☐ Other: _____

****Answer to the best of your ability according to the child's age*****

What type of symptom are you having? (Circle all that apply)

Pain Numbness Swelling Headaches Muscle Spasm Tightness Poor Posture

Loss of Range of Motion Other _____

Quality of symptom: (Circle all that apply)

Sharp Dull Aching Throbbing Stabbing Tingling Stiffness

Burning Radiating Other _____

Timing of pain:

Constant Frequent On and off Occasional

Severity of symptom (1 being no pain, 10 being disabled):

1 2 3 4 5 6 7 8 9 10

PREGNANCY HISTORY

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap/Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

BIRTH HISTORY

Was labor induced? _____ If yes, why? _____

What position did you deliver in? ☐ Squatting ☐ On back ☐ Other _____

Birth Trauma? ☐ Doctor assisted ☐ Twisting/Pulling ☐ Vacuum Extraction ☐ Forceps

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

If yes, please explain_____

INFANT HISTORY

Infant feeding:

_____Breast If so, how many months? _____ Prefer one side? _____ Frequent spit up? _____

Allergies/sensivities? _____

_____Bottle If so, which Formula? _____

Number of hours sleep per night _____ Quality of sleep: _____Good _____Fair _____Poor

Vaccination History: ☐ up to date ☐ Declined some vaccination ☐ Declined all ☐ Still deciding

# of doses of antibiotics in last 6 months: _____ During lifetime: _____

Has your child ever been treated at the emergency room? _____ If yes, please explain _____

Has your child ever been hospitalized? _____ If yes, please explain _____

Has your child ever had any surgeries? _____ If yes, please explain _____

Is your child currently on any medication? _____ If yes, please list: _____

Vitamins/Supplements? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy has been made available to me by Brecksville Physical Medicine. This describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

By signing this authorization you acknowledge and agree that Brecksville Physical Medicine may use or disclose medical records for the purpose(s) of receiving payment, insurance benefits, insurance denials, insurance audits, intent to reconcile account, intent to help patient and training purposes.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature _____ **Date** _____

Would you like a copy of the Privacy Notice (4 pages)? _____ Yes _____ No

Optional: In addition I would like to give my consent for release of health or financial information to the following individual (this does not include copies of medical records or reports):

Name _____Relationship _____Date of birth _____

Patient Signature _____ Date _____

CONSENT FOR TREATMENT / FINANCIAL POLICY

I _____(print name) do hereby agree and give my consent for Brecksville Physical Medicine to perform diagnostic procedures, render medical care and treatment judged medically necessary by our physicians.

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. I understand that the Doctor's Office 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 the Doctor's Office will be credit to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ **Date** _____

Consent to treat a minor

Patient Name: _____

Guardian Name: _____

Guardian Signature: _____ Date _____