Stillpoint Family Chiropractic, Inc.

CHILDREN'S HEALTH HISTORY FORM

Today's Date______________________

ABOUT THE CHILD

Name ____ Age ______ Date of Birth ______________________________

Gender ❑ M ❑ F Height _____________________ Weight ____________________________

Home Address ____________________________________City __________________ State ______ Zip ____________

Names and Ages of Siblings____

Parent A	Parent B
Name ____	Name ____
Home phone (________) _________________________	Home phone (________) _________________________
Cell phone (________) _________________________	Cell phone (________) _________________________
Employer ______________________________________	Employer ______________________________________
E-mail ____	E-mail____

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Stillpoint Family Chiropractic can address for your child? ____________________________

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Related to: ❑ Birth ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other ___________________________

Please describe how these concerns are affecting your child's quality of life. ____________________________________

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Check all that apply

- ❑ School
- ❑ Playing
- ❑ Communication
- ❑ Exercise/Sports
- ❑ Sleep
- ❑ Eating
- ❑ Walking
- ❑ Attention/Focus
- ❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

- ❑ Symptomatic relief of pain or discomfort.
- ❑ Correction of the cause of the problem as well as relief of symptoms
- ❑ Prevention of future problems
- ❑ Healthier spine and nerve system
- ❑ Optimal health on all levels
- ❑ OTHER____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:

❑ Experience any significant illnesses, difficulties, or trauma? ______________________________
❑ Take any drugs/medications? ____
❑ Smoke or consume alcohol

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks ____________________Weight ____________
Approximately how long did labor last? ___________ hours
Was labor artificially induced? ❑ No ❑ Yes ______________________________________
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes __________________

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications ______________
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck ______________

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones __________________________
❑ Feeding problem ❑ Displaced joints ❑ Other conditions __________________________

APGAR Score __________________

Was the baby breastfed? ❑ No ❑ Yes For how long? ______________________________________

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT ___________	❑ MMR ___________	❑ Other _____________
❑ Polio ___________	❑ Chicken Pox ___________	
❑ Hepatitis ___________	❑ Flu ___________	

Please describe any and all reactions to vaccine(s)____

Please check all that apply and give any necessary details:
❑ Child exposed to secondhand smoke.
❑ Has taken antibiotics. Explain ____
❑ Currently taking medication. Explain ____
❑ Currently taking supplements. Explain ____
❑ Has allergies. Explain ____
What treatments have you used? ____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to? ❑ Birth ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. ____
❑ Had a severe trauma. ____
❑ Been in an automobile accident. ____
❑ Has fractured a bone or dislocated a joint. ____
❑ Has/had a chronic illness. ____
❑ Has had surgery. ____

What physical activities does your child participate in? ____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. ___________________________________

Reason ___________________________________ How long? _______________ Date of last visit ______________

Why was care stopped? ____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason ____

Finances

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam: $55 X-Rays (if necessary): up to $200

INSURANCE INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. It is your responsibility to contact your insurance company to determine the amount and extent of coverage. **We do not submit any insurance forms for you. We are happy to provide an insurance friendly bill for you to forward to your insurance company.**

Is this an Auto Accident-Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Has your child been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other ______________________________

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy

❑ Other (details)____

PLEASE READ AND SIGN

1. I acknowledge that Stillpoint Family Chiropractic has informed me that they are not Insurance Providers. Therefore, they cannot guarantee that claims for any services rendered to me by Dr. Mary Grace Pennella or Stillpoint Family Chiropractic under any health plan will be reimbursed.

2. I have been informed that a copy of Stillpoint Family Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office.

3. I consent to receive communication from SFC via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Mary Grace Pennella permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon, such as xrays.

Child's Name: (Printed) ____

Parent or Legal Guardian's Name: (Printed)____

Signature ____ Date: ________________________

Thank you for choosing Stillpoint Family Chiropractic.

We look forward to helping you.