PEDIATRIC HISTORY

Date___________________

Name (first)_________________________________(mi)________(last)___________________________________

Address______________________________________ City__________________ State______ Zip_____________

Gender ☐Male ☐Female Birthdate(mm/dd/yyyy)________________ Age______ SSN________________

Mother's Name__________________________________ Father's Name________________________________

Home Phone #_______________ Mother's Work ph#________________ Father's Work ph#_______________

Birth Weight_________ Current Weight_________ Birth Length_________ Current Length/Height__________

Siblings Names & Ages ____

____

Referred to our Office by____

Purpose for contacting us____

Other Chiropractors seen for this concern____

Date of last visit_________________________ Reason for visit____

Other Doctors seen for this concern____

Date of last visit_________________________ Reason for visit____

Name of Pediatrician____

Date of last visit_________________________ Reason for visit____

Other health concerns? ____

Check any of the following conditions that may apply to your child:

☐Ear Infections	☐ Scoliosis	☐ Seizures	☐Chronic Colds	☐Digestive Problems
☐ Headaches	☐ Asthma/Allergies	☐ Colic	☐ Recurring Fever	☐ Growing/Back Pains
☐ Car Accident	☐ Bed Wetting	☐ ADHD	☐Temper Tantrums	☐ Other_________________

Number of Rounds of ***Antibiotics*** your child has taken:

In the last 6 months_____________________________ Total during lifespan_______________________

Number of Rounds of ***Other Prescription Medications*** your child has taken:

In the last 6 months_____________________________ Total during lifespan_______________________

Has your child received vaccinations? ☐No ☐Yes If yes, please list vaccines & dates_____________________

____

Prenatal History:

Name of Obstetrician/Midwife________________________ Location of birth: ☐Home ☐Birth Center ☐Hospital

Complications during pregnancy? ☐No ☐Yes If yes, please list___________________________________

Ultrasound exams during pregnancy? ☐No ☐Yes If yes, how many?__________________________________

Birth Interventions:

☐Induction ☐Artificial rupture of membranes ☐Forceps ☐Vacuum extraction ☐C-section, ER or planned?

Complications during Labor/Delivery?☐No ☐Yes If yes, please list___________________________________

Genetic Disorders/Anomalies? ☐No☐Yes If yes, please list____

Medications during pregnancy? ☐No ☐Yes If yes, please list____

Cigarette/Alcohol use during pregnancy? ☐No ☐Yes If yes, please describe_____________________________

Feeding History: Breast fed? ☐No ☐Yes How long? __________ Formula fed? ☐No ☐Yes How long?___________

Introduced to solid food at what age? ____________________; Cow's milk at what age? _________________

Food/juice allergies/intolerances ☐No ☐Yes If yes, please list_______________________________________

Habits	**Amount & Frequency**
___ Dairy	____
___ NutraSweet(aspartame)	____
___ Soda Pop (reg./diet)	____
___ Coffee	____
___ Snoring	____
___ Clenching/Grinding teeth	____

___ Carries heavy bag/backpack ☐Right side ☐Left side Sleep posture ☐Right side ☐Left side ☐Back ☐Stomach

Developmental History: During the following milestones of development, 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 and spinal nerve interference.

At what age was your child able to: ____Respond to sound ____Respond to visual stimuli(3+mos.)

____Hold head up(5-6mos.) ____Sit-up(9-10mos.) ____Cross Crawl ____Stand Alone ____Walk alone

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. from a bed, changing table, down the stairs, etc.) Is this the case with your child? ☐No ☐Yes

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, basketball, baseball, cheerleading, martial arts, etc.)? ☐No ☐Yes If yes, please list______________________

Has your child ever been in a car accident? ☐No ☐Yes If yes, please list_______________________________

Has your child ever been seen on an emergency basis? ☐No ☐Yes If yes, please list______________________

Prior surgeries? ☐No ☐Yes If yes, please list____

Date of first menstrual cycle (if applicable) ____________________

Childhood Diseases:

Chicken Pox ☐No ☐Yes Age_____ Mumps ☐No ☐Yes Age_____ Rubeola(Measles) ☐No ☐Yes Age_____

Whooping Cough ☐No ☐Yes Age____ Rubella(German Measles) ☐No ☐Yes Age_____

Other ____________ Age_____

Health Attitudes:

____***Treatment Only*** – I consult a doctor when I or my child have aches/pain and discontinue upon it's clearing up.

____***Prevention*** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

____***Maintaining health*** – I'm conscious about my health, diet, exercise, etc. and actively pursue these in order that I and my family feel better, perform better, and it maximizes each of our potential.

____***Family health*** – I take an active part in assisting and maintaining health with my family. I'm concerned with long term effects of good health and wellness.

Authorization for Care of Minor

I hereby authorize this office and its Doctors to administer care as they deem necessary to my son/daughter.

_________________________________ _________________________ ______________________

Parent/Legal guardian signature Witnessed by Date

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic x-rays (if needed), and any supportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts them known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment from my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: ____

Signature of Patient:_______________________________________

Name Printed of Guardian/Parental and Relationship to Patient:

____

Guardian/Parental Signature: ______________________________

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Dr. Jennifer Anacker.

Please list the individual(s) with whom we are able to share your health information, such as children, parents, or spouse.

Name: Relationship to you:

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____

____

Your name_______________________________ Phone_____________________

The effective date of this Notice of Information Practices is ____________________.

Thank you.