



Bluffton Family Chiropractic Pediatric Patient Introduction

Name: _____ Preferred Name: _____

Age: _____ Date of Birth: _____ Circle: Male or Female

Parent/Guardian Name: _____ Employer: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Address: _____

Does your child have Health Insurance? Y N (Please bring insurance card to front desk.)

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor: _____ Reason for leaving: _____

Present MD: _____ City: _____

Referred to our office by: _____ Relationship: _____

1. All visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. X-rays may be checked out to another doctor's office, but must be returned within 2 weeks.
3. Your signature below acknowledges that you are aware of our HIPPA policies. Policies are available from the receptionist upon request.
4. Patients with Insurance: Your signature below authorizes the release of any medical or other information necessary to process your claim. It also authorizes payment of medical benefits directly to our office for services performed in this office.
5. Authorization for care of minor: I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.
6. I give Bluffton Family Chiropractic permission to display my/family/children's photograph in its office and on its website. I understand that other patients or visitors will see these photos, as well as those who visit the website. No names will be displayed with these photos.

Parent/Guardian's Signature

Date

Why are you having your child's spine checked today? _____

On a scale of 1 to 10, how committed are you to helping us resolve your child's problem and/or helping them create a healthy lifestyle? _____

Pregnancy and Birth:

Length of Pregnancy: Full Term _____ or Other: _____

Complications during pregnancy: _____

Did you consume alcohol during your pregnancy? Y N How much? _____ How long? _____

Did you smoke? Y N How much? _____ How long? _____

Did you take any medication during your pregnancy? Y N

For what? _____ What type? _____

Birth place: Home Birth Center Hospital Other: _____

Care provider for labor and birth: Lay Midwife Nurse Midwife Ob/Gyn Other: _____

Type of Birth: Vaginal C-Section (please explain): _____

Procedures: Forceps Vacuum Extraction Other: _____

Drugs given in labor: Epidural Pitocin Other: _____

Was there a breech presentation? Y N Procedure used to turn baby: _____

Was labor artificially induced? Y N Drugs used to induce labor: _____

Number of ultrasounds performed on this child: _____

Did the mother have the Rhogam shot? Y N Was the shot given before or after the child's birth?

Diet and Drug History:

Feeding History: Breastfed? Y N How long? _____ Formula Fed? Y N How long? _____

Does/Did your child have problems nursing on a particular side? _____

Food allergies: _____

How often does your child have: Fast Food: _____ Soda: _____ Sweets: _____ Vitamins: _____

Number of doses of antibiotics your child has taken: Last 6 months: _____ Lifetime: _____

Other prescription drugs your child has taken and why: _____

Over-the-counter drugs your child has taken and why: _____

Do you vaccinate your child? Y N Reason for not vaccinating: Personal Belief or Medical necessity

Are you comfortable with your decision to vaccinate? Y N

Number of vaccinations your child has received: _____ Number that contain thimerosal: _____

Adverse reactions to the vaccinations: _____

Trauma and Surgical History:

What accidents and/or falls has your child suffered? _____

Has this child suffered any physical/mental/sexual abuse? _____

Has this child had any hospitalizations or surgical procedures (list reason and date) _____

Does your child complain of pain or headaches? _____

Are you concerned about the amount of weight your child carries in his/her book bag? _____

Behavior and Learning History:

Has your child been diagnosed with any behavioral or leaning disabilities? _____

Who made this diagnosis? _____

Are you concerned about your child's behavior or learning abilities? _____

Please list any other health care concerns you have about your child: _____

As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | | |
|--|---|---|
| <input type="checkbox"/> Fall from change table | <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Fall out of crib |
| <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Play Fall off playground equipment |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Tonsilitis | <input type="checkbox"/> Play in "Jolly Jumper" |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Did not gain weight | <input type="checkbox"/> Other _____ | |

Please explain the above: _____

As a young child, (5 to 12 years), did any of the following occur?

- | | | |
|--|---|--|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Fall off playground equipment |
| <input type="checkbox"/> Sports Accident | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Stomach Pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Leg/knee pains | <input type="checkbox"/> Other _____ | |

Please explain the above: _____

As a child or adolescent, has your child experienced any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arm/Wrist Pain | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Tingling in arms/legs | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Shoulder pains | <input type="checkbox"/> "Growing Pains" | |
| <input type="checkbox"/> Other _____ | | |

Please explain the above: _____