

PEDIATRIC PATIENT HISTORY

Date_____

Patient's Legal Name_____ Nickname_____

Age_____ Please Circle: Male Female Child's Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Parent's Work Phone_____ Cell_____

Parent/Guardian's name_____

Please list any pains, discomforts, illnesses or issues that your child is having:

Other doctors consulted for these conditions_____

Has your child seen a chiropractor before? Yes No If yes: Date of last adjustment_____

Pregnancy and Birth:

Mother's health during pregnancy_____

Medications mother took during pregnancy_____

Please circle:

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 or N Procedure used to turn baby_____

Was labor artificially induced? Y or N Drugs used to induce labor_____

Number of ultrasounds performed on this child_____

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

Diet and Drug History:

Feeding history: Breastfed:_____ How long?_____ Formula Fed:_____ How long?_____

Does your child have problems feeding 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 or N Reason for not vaccinating: Personal belief or medical necessity

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 their book bag _____

Behavior and learning history:

Has your child been diagnosed with any behavioral or learning 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: _____

Insurance and payment information:

Do you have any type of Health Insurance: Y N We will need to make a copy of your insurance card.

Method of payment you plan to use for today's charges: Check ___ Cash _____ Visa/MC _____

NOTICE: Not all patients require x-rays to determine or verify a diagnosis, type, or length of care. If your child's examination warrants x-ray analysis, the following prevails:

1. All first 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 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 their office and on their 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 signature _____ Date _____

*We are here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine your results.*