PEDIATRIC HISTORY FORM

Welcome to Core Health Chiropractic!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask!
Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

PATIENT DEMOGRAPHICS

Childs First Name
-

Childs Last Name
-

Date of Birth
-

Age
-

Today's Date
-

Birth Height
-

Birth Weight
-

Current Height
-

Current Weight
-

Address
-

City
-

State
-

Zip
-

Mother's Name
-

Mother's Mobile Phone
-

Email
-

Father's Mobile Phone
-

Fathers name
-

Email
-

Parents are currently:

☐ **Married** ☐ **Living together** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Pediatrician/Family MD
-

Last Visit Date:
-

Family Health History

Has anyone in the family had:

☐ **Motor problems**
☐ **Speech/Language problems**
☐ **Alcohol/Drug problems**
☐ **Seizures/epilepsy**
☐ **Reading problems**
☐ **School/Learning problems**
☐ **Anxiety/depression, other psychological disorders**
☐ **Attention problems**

Birth History

How would you describe your pregnancy?

-

Did you experience complications? If so, please list. Example: gestational diabetes, pre-eclampsia, high blood pressure, etc?

-

Did any stressful situations occur during pregnancy? Example, death in the family, loss of a spouse's job, separation, etc?

-

Please check what best describes your labor and birth of your child?

- ☐ Normal (no interventions)
- ☐ Complications during birth
- ☐ Rh factor problems
- ☐ Epidural given
- ☐ Cesarean section
- ☐ Forceps or suction used
- ☐ Mother was sick
- ☐ Problems with the umbilical cord
- ☐ Long/difficult labor
- ☐ Breech/facial/brow presentation
- ☐ Induced

Did your child have any of the following problems at birth?

- ☐ Difficulty breathing
- ☐ Bruising
- ☐ Required blood transfusions
- ☐ Jaundice
- ☐ Low birth weight
- ☐ Health Problems
- ☐ Nerve problems
- ☐ Intensive care
- ☐ Fever or seizures
- ☐ Problems with bones/joints
- ☐ Infection

Does/Did this child have any birth defects?

☐ yes ☐ no

If yes, details:

-

Describe what your childs temperament was/is as an infant:

☐ Difficult ☐ Irritable ☐ Sociable ☐ Calm

☐ Active ☐ Cranky

During the first 12 months, was/is this child:

- ☐ Sleepy
- ☐ Happy
- ☐ Frequently crying
- ☐ Easily scared
- ☐ Hyper sensitive
- ☐ Alert

Has the child had an delays with the following:

☐ Sitting ☐ Crawling ☐ Walking ☐ Toilet training

☐ Saying first words ☐ Using full sentences

Reason for Current Visit:

Purpose of this visit

☐ Wellness Check-up ☐ Injury or accident ☐ Other

Please explain:

-

If your child is experiencing pain/discomfort please identify where and for how long:

-

When did this problem first begin?

-

Ever had this problem before?

☐ Yes ☐ No

If yes, when
-

Any bowel or bladder problems since this problem began?
☐ Yes ☐ No

If yes, Describe
-

Has child seen any other doctors for this problem?
☐ Yes ☐ No

If yes who?
-

How long ago?
☐ Days ☐ Weeks ☐ Months ☐ Years

What were the results of past treatment?
-

How is this problem now?
☐ Rapidly improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening
☐ On & Off

Please list any medications/supplements taken:
-

Has your child ever sustained an injury playing organized sports?
☐ Yes ☐ No

If yes, Please explain
-

Has your child ever sustained an injury in an auto accident?
☐ Yes ☐ No

If yes, Please explain
-

Has your child ever suffered from:

☐ Headaches
☐ Seizures/Convulsions
☐ Sinus Trouble
☐ Fall in baby walker
☐ Orthopedic Problems
☐ Leg Problems
☐ Poor Posture
☐ Fall from bed or couch
☐ Digestive Disorders
☐ Reflux
☐ Hypertension
☐ Fall from crib
☐ Behavioral Problems
☐ Growing Pains
☐ Asthma
☐ Fall off swing
☐ Dizziness
☐ Heart Trouble
☐ Scoliosis
☐ Fall off bicycle
☐ Neck Problems
☐ Join Problems
☐ Anemia
☐ Fall from high chair
☐ Poor Appetite
☐ Constipation
☐ Colds/Flu
☐ Fall off slide
☐ ADD/ADHD
☐ Muscle Pain
☐ Walking Trouble
☐ Fall down stairs
☐ Fainting
☐ Chronic Earaches
☐ Bed Wetting
☐ Fall from changing table
☐ Arm Problems
☐ Backaches
☐ Colic
☐ Fall off monkey bars
☐ Stomach Ache
☐ Diarrhea
☐ Broken Bones
☐ Fall off skateboard/skates
☐ Ruptures/Hernia
☐ Allergies
☐ Sleeping Problems
☐ Other

If other was selected please explain
-

List any Allergies
-

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment:

-

What specific question do you have that you hope an evaluation will answer?

-

Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I hearby authorize payment to be made directly to Core Health Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Core Health Chiropractic for any and all services I receive at this office.

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time the claim is received. We will verify your benefits and outline them to you to the best of our knowledge. It is your responsibility to fully understand your insurance benefits. Payment is due at the time of treatment. I agree to pay Core Health Chiropractic all amounts that are due for services rendered, which includes deductible amounts, copays, and cash charges. We require a credit card to be kept on file to pay for these services.

Any applicable co-pay/deductible amount/cash rate is due at the time of service. Co-insurance, deductibles, and payments for non-covered services are the patient's responsibility. An itemized statement will be sent to you after your insurance company has processed your claim. We do require that a credit card be kept on file for balances that are not covered by insurance. Your credit card will be billed automatically for any unpaid balances. We do ask that you call us when you receive a statement if you would like to set up a payment plan. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, contact us immediately. We will try our best to set up a reasonable payment plan, if necessary. Payment on your account will be expected by the last day of each month. In the event that your account is not kept current, we reserve the right to send your account to collections. It is of utmost importance that you provide our office with complete responsible party information. It is our policy that we will collect payment at the time of service from any parent/guardian who may be bringing minor children to an appointment unless we are notified of other arrangements. In the event that there are legal or custody issues, please provide copies of legal documents to be kept as part of the patient's medical/financial record. Any patients with outstanding balances may be refused services in our offices until arrangements can be made with our billing department. We reserve the right to charge credit cards for any balances. We reserve the right to apply interest charges to accounts in which any portion is unpaid 45 days from the date of service and to charge for returned checks. Should the account be sent to collections, you will be responsible for additional collection fees ($75) as well as court costs and reasonable legal fees, if necessary.

Patients seeking services that require a referral are solely responsible for obtaining proper referrals from their Primary Care Provider. If you do not have a referral for your visit, you will have the option of paying for the visit IN FULL at the time of service or you will need to reschedule your appointment until the referral has been secured. Our office makes every effort to remind you when referrals are needed, but at no time does securing the referral become the responsibility of our office.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Insurance Company

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Policy #

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I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.
The risks associated with exposure to x-rays and spinal adjustments have been explained to me to my complete satisfaction, and I have
conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and
chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on
behalf of. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This
authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.
- In the instance of a no show without notice by phone we reserve the right to charge you a $25.00 fee using a credit card we have on file.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Signature

Date Signed

-

Printed Name

-

Email

-

How did you hear about us?

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