***Wolverton Chiropractic***

Pediatric Form (< 15 yoa)

Confidential Patient information (Please Print)

**Patient Information:**

Child's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Parent / Guardian's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status of Parents: M S W D

Would you like a text message reminder about your child’s appointments?  Yes  No

Do you have out of network benefits that will contribute to Chiropractic care?  Yes  No

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hobbies your child enjoy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been checked by a Doctor of Chiropractic?  Yes  No

Name of the Office & Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Were x-rays taken?  Yes  No

Who is your medical pediatrician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complaint History:**

What brings your child in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did it start? \_\_\_\_\_\_\_\_\_\_\_\_ Does it happen at any specific time of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it affect daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it happen at any specific time of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List care that your child has undergone for this complaint, including medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health History:**

**Prenatal History:**

Any complications with pregnancy? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is your child adopted?  Yes  No

Did you smoke or consume alcohol?  Yes  No

Reason for the medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you take medication?  Yes  No

**Birth History:**

Did you do regular ultrasounds? 3-D ultrasound? How many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth:  Home  Birthing center  Hospital

Provider:  Midwife  OBGYN  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Birth:  Vaginal  C-Section

What position did you deliver in?  Squatting  On Back  Other

Were pain medications used?  Yes  No Birth Trauma?  Fractures  Doctor assisted Twisting and/or Pulling  Vaccum extraction  Forceps

Was labor induced?  Yes  No If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Newborn Trauma** (medical procedures and tests):

APGAR score: birth \_\_\_\_\_/10 5-minutes\_\_\_\_\_/10  Unsure

Did your child have a misshaped skull / head?  Yes  No Jaundice (yellow) at birth?  Yes  No

Were there purple markings on their face?  Yes  No Did you breast feed your child?  Yes  No

Does your child prefer one breast over the other?  Yes  No If yes, which side?  R  L

Does your child have any food allergies?  Yes  No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been immunized?  Yes  No

Reason for vaccination?  Informed Decision  Recommended  Didn’t know I had a choice

Any negative reaction to vaccinations?  Yes  No Were they reported?  Yes  No

Has your child ever had any surgeries?  Yes  No If yes, please elaborate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been on antibiotics?  Yes  No If yes, how often and what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently taking any medication?  Yes  No If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently taking any vitamins?  Yes  No If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

Please estimate at what age did the following occur:

 Respond to sound\_\_\_\_\_ Crawl\_\_\_\_\_ Follow object with eyes\_\_\_\_\_

Hold Head up\_\_\_\_\_ Stand\_\_\_\_\_ Sit Alone\_\_\_\_\_

Walk Alone\_\_\_\_\_ Chickenpox\_\_\_\_\_ Rubella\_\_\_\_\_

Whooping cough\_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Baby/Toddler (0-4):**

Have any of the following occurred?

* Fall where the child hit their head (off changing table, out of crib, off playground equipment, down stairs)
* Frequent Crying Spell  Fall Down the stairs MVA  Play in Johnny Jumper
* Frequent Ear Infections  Tonsillitis Frequent Fevers  Frequent Diahhrea
* Constipation  Sleeping Problems  Repeated Infections  Colic
* Anemia  Blood Disorders  Heart problems  Problems walking/crawling
* (+ or -) weight  Other (Please Explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child (5-12 yoa):**

Have any of the following occurred?

 Fall from a tree  Fall off a bicycle  Sports accident  Stomach Pains

 Hyperactivity/ Autism  Scoliosis  Bedwetting Learning difficulties

* Asthma/ Allergies  Leg/ Knee Pains  MVA  Fall on Playground
* Behavior problems  Broken bones  Diabetes  Muscle Jerking

Which of the above bothers your child the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did it begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it getting worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is the pain: constant  intermittent

Does the pain affect your child’s activity? Which activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child participate in any of the following?

 Soccer  Football  Hockey  Wrestling  Swimming Lacrosse  Baseball Softball  Rugby  Gymnastics Basketball  Volleyball  Karate  Dance  Tennis  Other:

How would you rate your child’s diet?  Well Balanced  Average  High Sugar/ Processed Foods

Does your child consume artificial sweeteners?  Yes  No Fluoridated water?  Yes  No

Number of hours your child sleeps per night? Quality? \_\_\_\_ Per night  Good  Fair  Poor

AUTHORIZATION TO TREAT A MINOR

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigning parent/guardian, having legal custody/guardianship of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize, request and direct Dr. Suzanne and whomever she may designate as assistant to perform in judgment any treatment, physical examination, X-ray studies, laboratory procedures AND chiropractic diagnosis or treatment which is deemed necessary. I further authorize him/her to disclose all or any part of my (patient’s) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic’s charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patients employer. I understand that the doctor is prohibited from selling any part of my medical record.

INSURANCE & PAYMENT INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in out-of-network collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, and attorney’s fees in addition to above fees. I also understand that **all payments for services rendered are due at the time of service**. All fees for professional services rendered to me are immediately due and payable.

Date \_\_\_\_\_\_\_\_\_\_

Parent/ Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_