GREEN HILLS
Chiropractic Clinic

Pediatric Patient History

CHILD'S NAME: _____ AGE:_____ MALE FEMALE

LAST FIRST MI DOB:_____

MOTHER'S NAME: _____ FATHER'S NAME:_____

LAST FIRST LAST FIRST

ADDRESS: _____CITY/TOWN:_____STATE:_____ZIP:_____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

EMAIL: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: WEBSITE ____ SEARCH ENGINE____ WALK-BY____ SOCIAL MEDIA: _____

DOCTOR:_____ FRIEND:_____

THIRD TRIMESTER PRESENTATION: VERTEX _____ BREECH _____ TRANSVERSE _____ FACE/BROW _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ CESAREAN _____ SUCTION CAP OR VACUUM _____

LOCATION OF DELIVERY: BIRTHING CENTER _____ HOSPITAL _____ HOME _____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

HOW LONG DID LABOR LAST: _____

MEDICATION TAKEN DURING PREGNANCY: _____ CIGARETTE/ALCOHOL USE DURING PREGNANCY? ____

APGAR SCORES: _____ _____ WAS THERE PRESENCE OF: JAUNDICE (YELLOW) _____ CYANOSIS (BLUE) _____

CONGENITAL ANOMALIES/DEFECTS?_____ IF YES, PLEASE EXPLAIN: _____

INFANT FEEDING: BREAST_____ BOTTLE _____ IF BOTTLE, WHICH FORMULA? _____

NUMBER OF HOURS SLEEPING PER NIGHT:_____ QUALITY OF SLEEP: GOOD_____ FAIR _____ POOR_____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ CURRENT WEIGHT: _____ CURRENT LENGTH: _____

PURPOSE OF THIS APPOINTMENT: _____

OBSTETRICIAN/MIDWIFE:_____

PEDIATRICIAN/FAMILY MD: _____

DATE OF LAST VISIT: _____ PURPOSE: _____

PREVIOUS CHIROPRACTOR: _____

DATE OF LAST VISIT: _____ PURPOSE: _____

●●●●●●●●●●●●●●●AUTHORIZATION FOR CARE OF MINOR●●●●●●●●●●●●●●●

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY CHILD AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THE OFFICE.

INSURANCE COMPANY: _____ POLICY #: _____

SIGNED: _____ DATE: _____

Delivery/Birth History:_____

_____

_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain: _____

_____

Number of doses of antibiotics your child has taken: During the past six months _____ During his/her lifetime _____

Surgeries: _____

Medications: _____

Immunization History: _____

Accidents: _____

Family History: _____

Has your child ever been treated on an emergency basis? _____ If yes, why? _____

_____

At what age did the child…?

Walk alone_____ Talk_____ Crawl_____ Sit alone_____ Stand_____

Hold head up_____ Follow objects with his/her eyes_____ Respond to Sound_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chicken pox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping cough_____ Other_____

Has this child ever suffered from: (circle all that apply)

Dizziness	Backaches	Blood disorders	Leg/arm problems
Anemia	Headaches	Heart trouble	Back/neck problems
Poor appetite	Colds/Flu	Asthma	Orthopedic problems
Bed wetting	Rheumatic Fever	Sinus trouble	Digestive disorders
Seizures/convulsions	Hyperactivity/ADD/ADHD	"Growing pains"	Constipation/Diarrhea
Paralysis	Colic	Walking problems	Behavioral problems
Stomachaches	Car Accidents	Fainting	Chronic earaches
Broken bones	Scoliosis	Joint problems	Allergies to:_____
Allergies	Diabetes/Hypoglycemia	reflux	Allergies to:_____
Poor posture	Ruptures/hernias	Hypertension	Other:_____

We are here to serve you and encourage you to ask questions.
Your participation is vital and will help determine your results.
We will take GREAT care of you here!

PARENT/GUARDIAN INFORMATION

Child's Name _____ **Date** _____ **Patient #** _____

Parent Name _____

DOB _____ Male Female

Address _____

_____

City State Zip

Cell phone _____

Home Phone _____

Email _____

Status: single married divorced other _____

Employer Information:

Employer _____

Address _____

_____

City State Zip

Parent Name _____

DOB _____ Male Female

Address _____

_____

City State Zip

Cell phone _____

Home Phone _____

Email _____

Status: single married divorced other _____

Employer Information:

Employer _____

Address _____

_____

City State Zip

INSURANCE INFORMATION

Company Name _____ Insured ID# _____

Include alpha prefix please

Insured's Name _____ Relation _____

Insured's DOB _____ Group # _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company.

EMERGENCY CONTACT

Contact Name _____ Primary Phone _____

Relation to Patient _____ Secondary Phone _____

CONSENT TO TREAT

I give permission, as legal guardian of _____, for him/her to be seen and treated in my absence at Green Hills Chiropractic Clinic.

Parent/Guardian Signature:_____ Date:_____