IGNITE CHIROPRACTIC

PEDIATRIC HISTORY FORM

1 2 3 X

Today's Date: _____ HR#:_____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ◯ Male ◯ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Guardian's Name: _____ Relationship: _____ Guardian's Phone: _____

Guardian's Name: _____ Relationship: _____ Guardian's Phone: _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

Who is responsible for this bill/finances? _____ Relationship: _____

◯ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ◯ Wellness Check-up ◯ Injury or Accident ◯ Maintenance ◯ Problem ◯ Improved Health

Please explain: _____

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

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ◯ Unknown ◯ Gradual ◯ Sudden
2. How long has this problem lasted? _____ Days _____ Weeks _____ Months _____ Years
3. Has this problem occurred before? ◯ No ◯ Yes **If yes**, when?
   _____
4. Have you seen any other doctors for this problem? ◯ No ◯ Yes **If yes**, whom? _____
5. How Long Ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?
   ◯ Rapidly Improving ◯ Improving Slowly ◯ About the Same ◯ Gradually Worsening ◯ On and Off
8. Please list any medication(s) taken for this problem: _____
   a. # of doses of antibiotics your child has taken: Past 6 months _____Total Lifetime_____
   b. Past prescription drugs/dosage? _____
   c. Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____
9. Has your child ever sustained an injury playing organized sports? ◯ No ◯ Yes **If yes,** please explain_____
   _____
10. Has your child ever sustained an injury in an auto accident? ◯ No ◯ Yes **If yes,** please explain:

_____

_____

Child Name: _____ Date: _____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

- Headaches
- Dizziness
- Fainting
- Seizures/Convulsions
- Heart Trouble
- Chronic Earaches
- Sinus Trouble
- Asthma
- Broken Bones
- Allergies to

_____

- Orthopedic Problems
- Neck Problems
- Arm Problems
- Shoulder Problems
- Hip Problems
- Leg Problems
- Backaches
- Joint Problems
- Torticollis/head locked up

- Digestive Disorders
- Poor Appetite
- Stomach Aches
- Muscle Pain
- Constipation
- Diarrhea
- Hypertension
- Anemia

- Bed Wetting
- Colds/Flu
- Sleeping Problems
- Ruptures/Hernia
- Growing Pains
- Poor Posture
- Walking Trouble
- Scoliosis

- Colic/ Excessive Crying
- Frequent Tantrums
- Difficulty Latching/Nursing
- Social Challenges

- Behavioral Problems
- ADD/ADHD
- Projectile Vomiting
- Emotional Instability/ Anxiety

- Reflux/Spitting Up
- Speech Delays
- Frequent Stiffening/Rigidity

- Motor Milestone Delays
- Sensory Processing Issues
- Balance Issues

ACTIVITIES OF DAILY LIVING - *Check any area **affected** on a day-to-day basis (if applies)*

- Walking
- Sitting Cross Legged
- Socially Interact with Others
- Playing

- Static Standing
- Turning Head Left to Right
- Bowel Movements

- Static Sitting
- Concentrating
- Urination

- Sleeping
- Climbing Stairs
- Feeding/ Retaining Meals

LIFESTYLE - *Check all that apply*

Does your child: Eat healthy food (organic products, etc.) Drink water Take probiotics
Take vitamins Type: _____

Exercise: None Mild Moderate Heavy Daily

Hobbies/Interests: _____
_____

Is there anything else you would like us to know about your child? _____
_____

Child Name: _____ Date: _____

CHILDREN 2 YEARS AND YOUNGER- *please fill out the following*

Prenatal History- *check what applies*

Name of Obstetrician/Midwife: _____

Location of birth: ◯ Hospital ◯ Birth Center ◯ Home

Birth Intervention: ◯ Forceps ◯ Vacuum Extraction ◯ C-Section

If Cesarean Section, was it: ◯ Emergency ◯ Planned

Complications during pregnancy/delivery? ◯ No ◯ Yes **If yes**, explain: _____

_____

Ultrasounds during pregnancy? ◯ No ◯ Yes **How many**? _____

Medications taken during pregnancy? ◯ No ◯ Yes **List**: _____

Cigarette/ Alcohol use during pregnancy? ◯ No ◯ Yes

Genetic Disorders/disabilities? ◯ No ◯ Yes **List**: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: ◯ Good ◯ Fair ◯ Below Normal

Feeding History

Breast Fed: ◯ No ◯ Yes How Long? _____ Formula Fed? ◯ No ◯ Yes How Long? _____

Type of Formula: _____

Introduced to: Solid Foods @ _____ months Cow's milk @ _____ months

Food/ Juice allergies or intolerances: ◯ No ◯ Yes **List**: _____

*According to the National Safety Council, approximately 50% of children fall head first from a high place during their **first year of life** (i.e. a bed, changing table, down stairs) -PLEASE CHECK WHERE THIS APPLIES BELOW

◯ Fall from crib ◯ Fall off swing ◯ Fall from bed or couch ◯ Fall down stairs
◯ Fall in baby walker ◯ Fall off bicycle ◯ Fall from high chair ◯ Fall off slide
◯ Fall from changing table ◯ Fall off monkey bars ◯ Fall off skateboard/skates
◯ Other:

_____

Developmental History- *To the best of your knowledge*

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interferences). Spinal nerve interference can affect the progression of milestones & developmental stages.

At what number of weeks, months or year was you child able to:

Respond to stimuli (voice, loud sound): _____ weeks/ months
Respond to visual stimuli:_____weeks/ months
Sit up : _____ weeks/ months
Stand alone: _____months/ year

Hold head up:_____ weeks/ months
Push Up on Tummy: _____weeks/ months
Cross Crawl: _____months/ year
Walk alone: _____months/ year

Child Name: _____ Date: _____

CONSENT & RESPONSIBILITY

I understand that I am directly and fully responsible to Ignite Chiropractic PLLC for all fees associated with chiropractic care my child receives.

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES. PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF IGNITE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

The risks associated with exposure to ionization 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.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL X-RAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE. BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

CHILDS NAME _____ CHILDS AGE _____

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Name of Child or Minor:_____ Date :_____

Legal Guardian's Signature:_____ Date :_____

Child Name: _____ Date: _____

(OPTIONAL) CONSENT FOR PHOTOS CAPTURED

We love to have kids' pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by IGNITE CHIROPRACTIC PLLC, or anyone authorized by IGNITE CHIROPRACTIC, of any and all photographs/videos which were taken of my child, for the purposes of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of IGNITE CHIROPRACTIC, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned.

Confidentially, regarding any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize IGNITE CHIROPRACTIC to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Parent/Guardian Signature: _____ Date: _____