**Pediatric History Form**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Parents / Guardians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_
Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Birth Date \_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Reason for seeking chiropractic care**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other Doctors seen for this condition Y/N Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Prior treatment and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Symptoms:** Please check any current or past problems your child has on the list below:

\_Dizziness

\_ADHD

\_Backaches

\_Heart Condition \_Chronic Earaches
\_Diabetes \_Tuberculosis \_Hypertension

\_Fever/Chills

\_Frequent Colds
\_Arthritis

\_Headaches

\_Asthma

\_Allergies

\_Runny Nose

\_Itchy Eyes

\_Rashes
\_Ear Infection

\_Digestive Trouble

\_Sinus Trouble

\_Cough/Wheeze

\_Chest Pain \_Constipation
\_Anemia

\_Latching Difficulty

\_Reflux

\_Diarrhea
\_Poor Appetite \_Hyperactivity

\_Behavioral Issues

\_Poor Memory

\_Insomnia

\_Nightmares
\_Bed Wetting

\_Pain Urinating

\_Convulsions

\_Paralysis

\_Muscle Pain
\_Fainting

\_Broken bones \_Sprains/Strains

\_Colic
\_Neck Pain

\_Arm/Elbow Pain

\_Leg/Hip Pain

\_Knee/Foot Pain

\_Growing pains
\_Joint Pain

\_Scoliosis

\_Blood disorders \_Stomach Aches

\_Other

**Health History**:
Name of Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_
Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Medications and conditions being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child ever taken antibiotics? Y/N Condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child ever been involved in a car accident? Y/N Date & Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other traumas not described above? Y/N Type & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Prior surgery: Y/N Type and Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Prenatal History**Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications during pregnancy/delivery: Y/NList: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: O Forceps O Vacuum O Caesarian, Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Complications during delivery: Y/N List: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Genetic disorders or disabilities: Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Birth weight\_\_\_\_\_\_\_\_ Birth length\_\_\_\_\_\_\_\_\_ APGAR scores: 1 min \_\_\_\_\_ 5 min \_\_\_\_\_
**Feeding history**
Breast Fed: Y/N How long’?\_\_\_\_\_\_\_\_\_\_\_ Formula fed: Y/N How long’?\_\_\_\_\_\_\_\_\_\_\_
Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Introduced to solids at \_\_\_\_\_ months.

Food / juice allergies or intolerances Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Developmental History**Sleep (Hrs per night) \_\_\_\_\_\_\_ Naps (number & lengths) \_\_\_\_\_\_\_\_\_\_\_\_\_ Problems sleeping \_\_\_\_\_\_\_\_\_\_
At what age was your child able to: Crawl \_\_ Sit alone \_\_ Stand alone \_\_ Walk alone \_\_ Say words \_\_

**Childhood Diseases**O Chicken Pox - Age \_\_\_ O Mumps - Age \_\_\_ O Rubella - Age \_\_\_ O Whooping cough -Age \_\_\_
O Measles - Age \_\_\_ O Meningitis - Age \_\_\_ O Tuberculosis - Age \_\_\_ O Other - Age \_\_\_\_\_\_\_\_\_

**Vaccination History:**

O HBV / Hep B (Hepatitis B) – Age \_\_ O MMR (Measles, Mumps, Rubella) – Age \_\_

O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age \_\_ O Varicella (Chicken Pox) – Age \_\_

O HbCV / Hib (H. influenzae type b conjugate) – Age \_\_ O PCV (Pneumoccocal) – Age \_\_

O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age \_\_

Adverse Reactions to Any Vaccine? Y/N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pediatrician notified of adverse reaction to vaccine? Y/N

**Patient Acknowledgment and Authorization**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctors of Chiropractic, Matthew Essington DC and Tara Essington DC.

I have had an opportunity to discuss with the doctor of chiropractic the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Financial Responsibility**

The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care.

I fully accept the financial responsibility to pay 608 Chiropractic PC for all services rendered.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (Guardian) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Practices-Patient Reception Form

 I have received or reviewed the privacy notice (5 pages) for 608 Chiropractic PC and Massage by Miles, understand the situation in which this practice may need to utilize or release my medical records. I also understand that I agree to the use of those records when I initially applied for care whenever that may have occurred.

 I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (Guardian) Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name

I hereby give 608 Chiropractic PC and Massage by Miles, permission to release my medical records to the following people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_