Edgewood Chiropractic Center
1114 W Cook Road Fort Wayne, IN 46825
(260) 483-5588

PEDIATRIC Chiropractic Case History/Patient Information

Office use:
Date:_____ Patient # _____ Doctor:_____

CHILD'S NAME: _____

PARENT/GUARDIAN NAME: _____ SSN_____-_____-_____

HOME PHONE:__(_____)_____-_____ CELL PHONE:__(_____)_____-_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

E-MAIL ADDRESS:_____@_____

AGE:_____ BIRTHDATE:_____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

HOW WERE YOU REFERRED TO OUR OFFICE:_____

FAMILY MEDICAL DOCTOR:_____ last physical examination_____

TYPE OF BIRTH (circle): VAGINAL FORCEPS BREECH VACUUM VBAC C-SECTION

HOMEBIRTH HOSPITAL BIRTHING CENTER IVF SURROGATE ADOPTION OTHER: _____

Problem during pregnancy? _____

Problem during labor/delivery? _____

APGAR Scores _____ & _____ Present at birth (circle): Jaundice (yellow) Cyanosis (blue)

Congenital Anomalies/ Genetic Syndrome: _____

Infant Feeding (circle): BREAST BOTTLE FORMULA Any issues? _____Quality of sleep: _____

Immunization History: _____ Childhood diseases?_____

DEVELOPMENTAL HISTORY: At what age did your child perform the following:

*** PLEASE USE A STAR IF THEY HAD DIFFICULTY PERFORMING***

SMILE: _____ HOLD HEAD UP: _____ ROLL: _____ HOLD OBJECT W/ HANDS: _____ CRAWL: _____

SIT ALONE: _____ TALK: _____ STAND: _____ WALK ALONE: _____ TALKING: _____

REASON FOR VISIT: _____

Has your child ever suffered from (circle all that apply)

tourette's syndrome	stomachaches	ear infections	bed wetting
colic	constipation	reading problems	fainting
asthma	diarrhea	learning disability	neck pain
allergies	diabetes	dysgraphia	headaches
food sensitivities	ruptures/hernias	dyspraxia	joint pain
hyperactivity	paralysis	cold/flu	rheumatoid arthritis
sensory processing issues	behavioral issues	walking problems	seizures

Parent/Guardian Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

Patient Name:_____ Patient No:_____

Medical History:

Please check all that apply:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Alcoholism	≤	≤	
Arthritis	≤	≤	
Asthma	≤	≤	
Broken/Fractured Bones	≤	≤	
Cancer	≤	≤	
Circulatory Problems	≤	≤	
Coughing Blood	≤	≤	
Depression	≤	≤	
Diabetes	≤	≤	
Drug Addiction	≤	≤	
Epilepsy	≤	≤	
Excessive Bleeding	≤	≤	
Heart Disease	≤	≤	
High/Low Blood Pressure	≤	≤	
Kidney Disease	≤	≤	
Liver Disease	≤	≤	
Lung Disease	≤	≤	
Mental Illness	≤	≤	
Osteoarthritis	≤	≤	
Back Pain	≤	≤	
Neck Pain	≤	≤	
Seizures/Convulsions	≤	≤	
Stroke/Hypertension	≤	≤	
Ulcers	≤	≤	
Other:			
Other:			

HOSPITALIZATIONS (Please list surgeries): _____

Has your child had any major illnesses, injuries, falls or auto accidents? _____

Please list any CURRENT MEDICATIONS: _____

Social History:

Does your child take vitamin supplements? ≤ YES ≤ NO If so, please list:_____

Does your child exercise/ play sports? ≤ YES ≤ NO If yes, what is the frequency and type?_____

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HIPAA Privacy Notice

Edgewood Chiropractic Center strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time you may request to view or receive a copy of our HIPAA policy.

To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA policy has been made available to you upon request.

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are due at the time of service, unless prior arrangements have been made.

Our office accepts assignment with most insurance companies, however **insurance is not a guarantee of payment**. Your insurance is an agreement between you and your insurance company. All insurance assignment patients must pay their deductibles in full and copayment/coinsurance at time of service. If our office has not received payment by your insurance company within forty five (45) days of our office filing the claim, you will become responsible for payment in full.

I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to, the examination, consultation, and/or treatment. I also agree to pay a service charge of $35.00 if my check is returned for insufficient funds. I understand that this service charge may be in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month may be assessed on delinquent balances. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my account.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic at Edgewood Chiropractic Center and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN AFTER YOU AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative (if patient is a minor or POA) Date

x_____ _____
Witness to Patient's Signature Date

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Pain Chart

Patient's Name:_____

Please make a slash through this line to indicate the level of your pain.

No Pain **Worst Pain Possible**

Draw location and type of pain on the body outline.

Pain Representation

Ache:
v v v v v v v v

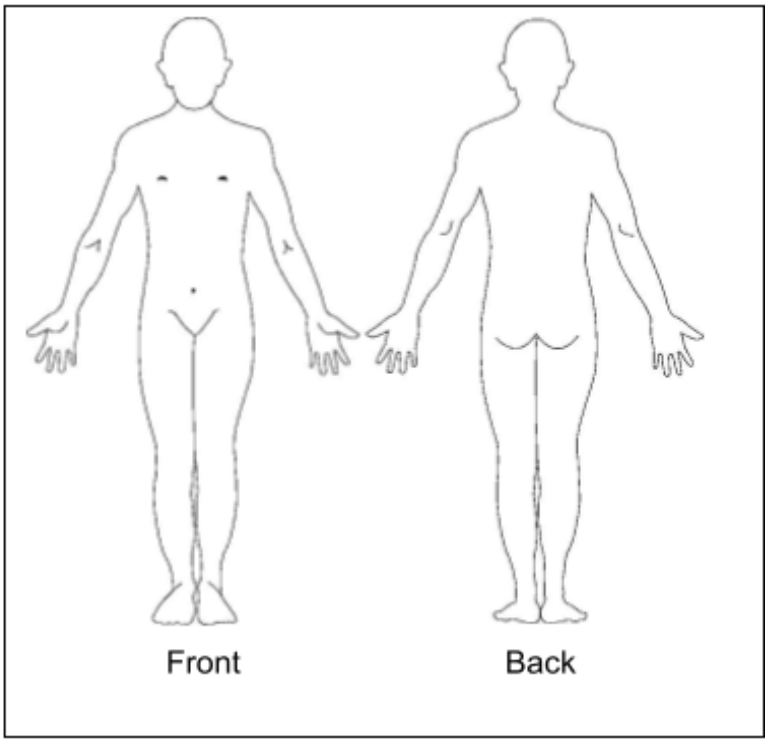
Burning:
= = = = = = = =

Numbness:
O O O O O O O

Pins & Needles:

Stabbing:
/ / / / / / / / /

Other:
x x x x x x x



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Patient's Signature Date