PEDIATRIC HEALTH HISTORY

Full Name:_____ (Preferred Name:_____)

Today's date:_____

Address:_____

City: _____State: _____ Zip: _____

Age: _____ Date of Birth: _____ Gender: M / F SSN: _____

Parent A

Name:_____

Cell phone: (_____)_____

E-mail:_____

Parent B

Name:_____

Cell phone: (_____)_____

E-mail:_____

➔ Apptointment reminder text/email will be sent to Parent A unless otherwise instructed. You may opt out.

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel need to be addressed for your child?_____

_____

Please indicate below how these concerns are affecting your child's quality of life. (Circle all that apply)

School	Exercise/Sports	Walk/Crawl	Playing	Sleep
Attention/Focus	Communication	Eating	Digestion	Daily Routine

Other:_____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? Yes or No

If yes, for what reason: _____

How long? _____ Date of last visit_____

Why was care stopped_____

Have you consulted, or do you regularly consult any of the following providers for your child?

Circle all that apply:	Medical Physician	Naturopath	Acupuncturist	Homeopath
	Physical Therapist	Psychotherapist	Energy Healer	Massage

Other_____

Reason:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called vertebral subluxation. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional, and chemical causes and effects.

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating vertebral subluxations.

PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system.

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? N / Y , List:_____

Take any drugs/medications? N / Y , List:_____

Smoke or consume alcohol? N / Y , List:_____

Was the delivery premature? N / Y Weeks:_____ Weight:_____

Approximately how long did labor last? _____hours; Was labor artificially induced? N / Y

Was the child in a breech position (butt down) or otherwise mispositioned? N / Y

Circle where the child was born & if any of the following were administered during labor and birth.

Home birth / Hospital birth / other _____

Vaginal Water birth Caesarean Epidural Forceps Vacuum Medications
Pitocin Episiotomy Manual traction of the neck OTHER: _____

Please check all that apply to the child's status immediately after birth: APGAR Score_____

Jaundice Respiratory problems Broken bones:_____
Feeding problem Displaced joints Other conditions:_____

Was the baby breastfed? N / Y , For how long? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

□ Uncoordinated/Accident prone_____
□ Has been hospitalized_____
□ Had a severe trauma or concussion_____
□ Been in an automobile accident_____
□ Has fractured a bone or dislocated a joint._____
□ Has/had a chronic illness._____
□ Has had surgery._____

What physical activities does your child participate in?_____
_____

FAMILY CHIROPRACTIC OF CHATTANOOGA, INC. 6341 EAST BRAINERD ROAD, CHATTANOOGA, TN 37421 423-355-5437 / LIFE@FCOCHAT.COM

PATIENT NAME:_____ DATE OF BIRTH:_____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or encounters the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? N / Y

If yes, please check all vaccinations the child has received and at what **age** they were administered:

□ DPT _____ □ Polio _____ □ Hepatitis _____ □ MMR _____ □ Chicken Pox _____ □ Flu _____

Other _____Describe all reactions to vaccine(s)_____

_____

Please check all that apply and give any necessary details:

□ Child exposed to secondhand smoke._____

□ Has taken antibiotics. Explain:_____

□ Currently taking medication. Explain:_____

□ Currently taking supplements. Explain:_____

□ Has allergies. Explain:_____

What treatments have you used?_____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.

Indicate if your child has ever or is currently experiencing any of the emotional stresses below: (check all that apply)

□ Academic pressure □ Loss of a loved one □ Bullying □ Relocation

□Lifestyle change □ Parents' divorce □ Loss of a pet □ New sibling

Does your child have difficulty interacting with schoolmates or friends? Y / N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Y / N

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like my child to experience the following benefits from Chiropractic Care: (Check all that apply)

□ Symptomatic relief of a problem □ Prevention of future problems

□ Healthier spine and nerve system □ Optimal health on all level

□ Other_____

PATIENT NAME:_____ DATE OF BIRTH:_____

CONSENTS / ACKNOWLEDGEMENTS

- I understand that most care is given in an open adjustment office setting.
- I consent to receive communication from the office in connection with my child's care via postal mail, email, text, & telephone messaging. **If I withdraw my consent, I will notify the office in writing*.
- A copy of the privacy policies was given for review & is always available at the front desk.
- This initial visit includes a health history consultation, chiropractic exam and evaluation followed by any initial care that is determined to be clinically necessary and mutually agreed upon.
- The information I have provided on this case history form is true and accurate to the best of my knowledge.
- I give the doctors at Family Chiropractic of Chattanooga permission to render care to my child today.
- I agree that I am responsible for paying for all services received in this office.
- If this account gets placed with attorney or collections, I am responsible for all fees.
- I assign this office the right to collect payments from all third-party payers, such as insurance.
- I authorize the release of any medical or other information necessary to process claims.
- The office will not enter into a dispute with your insurance company; we will provide you with the information needed.
- Emergency/Weekend/Afterhours appointments will be charged $75.00 (not billed to insurance)
- ***Missed appointments, without 24-hours' notice, may be charged $15.00.**
- ****PAYMENT: CASH, CHECK, or CREDIT [credit cards kept on file will be used to pay your balances due]**
- ***** Other than the parents listed on first page, I give FCOC, Inc. consent to discuss medical issues/chart details with specific individuals, listed below:**

Name	Relationship	Contact#	Details you want us to know about them.

By signing below, I agree to all consents and authorize this office to perform necessary exam & treatment.

Parent / Guardian Authorizing Care - Signature: _____

Printed Name: _____

Today's Date: _____

Are we billing insurance for your child's care? NO / YES: Insurance Co. Name:_____

Whom may we thank for referring you to our office?_____