FAMILY FIRST CHIROPRACTIC & WELLNESS
CHILD'S HEALTH HISTORY FORM

PERSONAL DATA

Today's Date_____

Name_____ Age _____ Date of Birth _____

Parent's names_____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Parent's occupation _____

Business Address_____ City_____State_____ Zip _____

SS# (opt'l)_____ Emergency contact _____

Names and ages of child's siblings if he/she has any_____

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

REASON FOR SEEKING CHIROPRACTIC CARE

How do you think we may help be able to help your child? _____

_____

Are these concerns affecting your child's activities of daily living? (Circle Y to those that apply)

Eating:	Y	N	Sleep:	Y	N	Running:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Relationships:	Y	N	Other: _____		

PREVIOUS CHIROPRACTIC CARE

Has your child ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____ months ❑ years_____

Date of last visit: _____

FOR MOMS

Tell us about your pregnancy.

Did you carry full term? ❑Y ❑ N If no, explain. _____

Describe any other complications if any. _____

Did you have any ultrasounds? ❑Y ❑ N If yes, how many? _____

YOUR BABY AT BIRTH

Did you use a midwife? ❑Y ❑ N Was your baby born at home, birthing center, or hospital? _____

Did you have a C-section? ❑Y ❑ N Were forceps used? ❑Y ❑ N Vaccum extraction? ❑Y ❑ N

Did you have an epidural? ❑Y ❑ N Was it a difficult birth? ❑Y ❑ N

Explain if needed. _____

_____

Hospital staff score a new born baby using an APGAR scale. It is taken at one minute after birth and again at five minutes after birth. If you happen to know your baby's score please write it in blanks, if not, the doctor may obtain this information from you child's birth record if necessary.

APGAR at one minutes _____ at five minutes _____

TELL US MORE

Did you breastfeed? ❑Y ❑ N How long? _____

Did you bottle feed the baby with formula? ❑Y ❑ N What brand of formula? _____

Did you take any medication during your pregnancy? ❑Y ❑ N

What medication and why? _____

As a baby or toddler, did any of the following occur?

___ fall from a changing table ___ frequent crying spells ___ frequent fevers

___ tumble from stair ___ fall out of crib ___ frequent bouts of diarrhea

___ involved in car accident ___ constipation ___ sleeping problems

___ play in jumper ___ frequent colds ___ colic

___ tonsillitis ___ fall off playground equipment ___ did not gain weight

___ reaction to vaccination ___ other _____

Explain any of the above if needed: _____

_____

Has your child ever had any vaccinations? _____

Did your child ever have any reactions to any vaccinations? _____

Has your child experienced any of the following?

___ headaches ___ numbness in arm/hands ___ foot/ankle/knee pains

___ dizziness ___ arm/wrist pains ___ tingling in arms/legs

___ ringing in ears ___ sleeping problems ___ neck/back pain

___ asthma ___ allergies ___ shoulder pains

___ hyperactivity ___ stomach problems ___ growing pains

___ fatigue ___ weight gain or loss ___ other _____

Which of the above that you checked would you consider the worst?_____

_____

Do any of the following still occur? _____

If yes, list which ones. _____

Is this condition: ___ constant ___ intermittent ___occasional ___cyclic

QUALITY OF LIFE

When this condition is at its worst, how does it make your child feel? _____

_____

Is there anything you have done for your child regarding this condition that has NOT worked? _____

_____

Describe any hospital or emergency room stays? _____

_____

Approximately how many times have antibiotics been prescribed for your child and for what conditions?

_____

List any medications your child is currently taking: _____

_____

Is there anything else you think we should know about your child?_____

_____

EXPECTATIONS

I would like to have the following benefits for my teenager from ***Chiropractic Care***: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels

YOUR INFORMED CONSENT

The information I have provided on this case history form, is true and accurate to the best of my knowledge. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know: 1. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported; 2. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause. Chiropractic care has been proven to be both, clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I have been informed and fully understand that Chiropractic care is not a treatment of any disease or condition. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Signature _____ Date _____

Signature of Parent (for Minor) _____ Date _____

FINANCIAL RESPONSIBILITY

Family First Chiropractic & Wellness

In return for services rendered to me by Family First Chiropractic & Wellness, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

Assignment of Benefits – I understand that Family First Chiropractic and Wellness Center is not a provider for my insurance company or any insurance company. I understand that benefits I may try to claim form my insurance company for services rendered at this Wellness Center quoted from my insurance carrier are only an estimate and not a guarantee of payment.

Medicare – I acknowledge that Family First Chiropractic & Wellness is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Release of Medical Information and Records
By signing below I authorize Family First Chiropractic & Wellness to release all medical information and/or records requested by my insurance company or any referring doctor. By signing below I also authorize Family First Chiropractic & Wellness to use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment.

Acknowledgment of Privacy Practices
I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Family First Chiropractic & Wellness, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (or legal Guardian) Date