PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name_____ Date of Birth _____/_____/____

Age: _____ Birth Height: _____ Birth Weight: _____ 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: ____/____/____ Reason for visit: _____

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

☐ Other *(please explain):*_____

_____

CHILD'S CURRENT PROBLEM:

Purpose of visit: ___ Principled Chiropractic ___Wellness Check-up ___Injury/Accident ___Other

Please explain: _____

If your child is experiencing Pain/Discomfort, please identify where and for how long:

_____

_____

1. **When did the problem first begin?** Date ____/____/_____
   _____Gradual _____Sudden

2. **How long has this problem lasted?**
   _____ Days _____ Weeks _____ Months _____Years

3. **Ever had this problem before?** _____ No _____ Yes; If yes when? _____

4. **What were the results of past treatment? _____**

5. **How is this problem NOW:**
   ___ Rapidly Improving ___ Slowly Improving ___ About the Same
   ___ Gradually Worsening ___ On & Off

6. **Please list any medication taken for this problem: _____**
   _____

7. **Has your child ever sustained an injury in an auto accident?** ____ No ____ Yes
   If yes; please explain: _____

_____

Symptoms and Dysfunctions

(Check all the apply)

_____ Neck Problems
_____ Shoulder Pain
_____ Upper Back Pain
_____ Mid Back Pain
_____ Low Back Pain
_____ Scoliosis
_____ Arm Problems
_____ Leg Problems
_____ Hip Problems
_____ Muscle / Growing Pain
_____ Joint Problems
_____ Poor Posture

_____ Headaches
_____ Migraines
_____ Ear Infections
_____ Allergies / Sinuses
_____ Cold / Flu
_____ Asthma
_____ Digestive Issues
_____ Constipation
_____ Diarrhea
_____ Heart Problems
_____ Anemia

_____ Bed Wetting
_____ Torticollis (downward tilt of head)
_____ Colic / Excessive Crying
_____ Difficulty Latching / Nursing
_____ Reflux / Excessive Spit Up
_____ Projectile Vomiting
_____ Frequent Stiffening / Rigidity / Arching
_____ Difficulty Sleeping

_____ Motor Milestone Delays
_____ Speech / Communication Delays
_____ Sensory Processing Challenges
_____ Social / Emotional Challenges
_____ Behavioral Issues / Frequent Tantrums
_____ Hyperactivity / Impulsivity
_____ Anxiety / Emotional Instability
_____ ADD / ADHD
_____ Balance Issues

ACTIVITIES OF DAILY LIVING

Please identify how the current condition is affecting their ability to carry out activities that are routinely part of their life:

_____ Walking
_____ Do Static Sitting
_____ Do Static Standing
_____ Sleeping
_____ Sitting Cross-Legged
_____ Turning Head Left to Right

_____ Concentrating
_____ Socially Interact with Others
_____ Climbing Stairs
_____ Using the Bathroom (Bowel/Urine)
_____ Feeding/Retaining Meals
_____ Playing

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain _____Worst possible pain

0 1 2 3 4 5 6 7 8 (9) 10

1. How would you rate your pain RIGHT NOW?

_____

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

_____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1____+Q2____+Q4____=____ /3x10=____ (Low Intensity = <50; High Intensity = >50)

Terms of Acceptance

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

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.

☐ 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.

_____ _____

Legal Guardian's Signature **Date**

_____ _____

Doctor or CA's Signature **Date**

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**