Danville Chiropractic Case History and Patient Information
Pediatric Form

Name: _____ Date of Birth: _____/_____/_____ Date: _____/_____/_____

Preferred to be called: _____Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

Parent #1 Name:_____ Work/Cell#_____

Parent #2 Name:_____ Work/Cell#_____

Insured Parent's SSN#_____ Insured Parents Date of Birth:_____/_____/_____

Parents Email Address:_____

BIRTH INFORMATION

Type of Birth ☐ Vaginal ☐ Forceps ☐ Breech ☐Cesarean ☐ Home ☐ Birthing Center_____ ☐ Hospital_____

Birth Weight: _____ Birth Length:_____ Apgar Score:_____

At Birth Jaundice (yellow): ☐ Yes ☐ No _____ Epidural ☐ Yes ☐ No

Please List any problems during pregnancy and/or labor:_____

_____

_____

Congenital Anomalies/Defects:_____

Infant Feeding(check all that apply): ☐ Breast ☐ Bottle ☐ Formula ☐ Other food or drink Information_____

# of hours child sleeps daily_____ Quality of sleep: ☐ Good ☐ Fair ☐ Poor

Explain:_____

# of siblings:_____ Please list names and ages:_____

_____

MEDICAL HISTORY

Pediatrician and/or Family Doctor Name:_____ Location_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Date of Last Visit to Doctor:_____ Purpose of Visit:_____

_____

Immunization History:_____

_____

Has your child ever been treated on an emergency basis? ☐ Yes ☐ No Please describe:_____

_____

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HEALTH INFORMATION:

Reason for visit today:_____
_____

_____

Condition Started on:_____

Is Condition getting progressively worse? ☐ Yes ☐No Please describe:_____

Other doctors seen for this condition:_____

Any home remedies?_____

Developmental History- at what age did the child:	Childhood Diseases-age of child when occurred:
Respond to sound:_____	Chicken Pox: _____
Crawl:_____	Rubella: _____
Follow an object with their eyes:_____	Rubeola: _____
Hold Head up:_____	Whooping Cough:_____
Stand:_____	Mumps:_____
Sit alone:_____	Measles:_____
Walk alone:_____	Other:_____

Has the child ever suffered from any of the following (please check all that may apply):

☐Diabetes	☐Bed Wetting	☐Convulsions	☐Neck Problems
☐Fainting	☐Tuberculosis	☐Backaches	☐Heart Trouble
☐Dizziness	☐Stomach Aches	☐Allergies	☐Orthopedic Problems
☐Asthma	☐Walking Problems	☐Rheumatic Fever	☐Hypertension
☐Sugar Concentration	☐Headaches	☐Blood Disorders	☐Sinus Troubles
☐Leg Problems	☐Broken Bones	☐Sleeping Problems	☐Digestive Disorders
☐Diarrhea	☐Constipation	☐Paralysis	☐Joint Problems
☐Arm Problems	☐Hyperactivity	☐Chronic Earaches	☐Colds/Flu
☐Arthritis	☐Neuritis	☐Anemia	☐Poor Appetite
☐Behavioral Problems	☐Muscle Jerking	☐Ruptures/Hernias	☐ "Growing Pains"

☐Any Other Problems:_____

Present Health History or Additional Information:_____

Has the child had any surgeries? ☐ Yes ☐ No What and When? _____

_____

Accidents:_____

_____

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Medications:_____	Vitamins: :_____
_____	_____
_____	_____

FAMILY HISTORY:

	Hearth Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Please check any and all insurance coverage that may be applicable in this case:

☐ Medicaid ☐ Medicare ☐ Major Medical (Please See Note Below)

☐Medical Savings Account & Flex Plans ☐ Other_____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **If your account should become 90 days past due your account will be submitted for collections. Any collection fees will be solely patient's responsibility.**

PLEASE NOTE: On **your first visit, payment is due in full at the time of service, unless prior arrangements were made**. We DO accept insurance assignment, but NOT until we are able to contract your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

By signing you are authorizing Danville Chiropractic to perform a complete examination, provide chiropractic care, and other therapeutic treatment to your child. This authorization is also intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named on form. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other legal authorization is not required. If my authorization to so select and authorize this care should be revoked or modified in any way, I will immediately notify the office.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you want to receive your medical records, please inform our office.

Guardian's Signature Authorizing Care: _____ Date: _____/_____/_____

Relationship to Patient ☐Mother ☐Father ☐Legal Guardian ☐ Other:_____

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SUMMARY

1. What is/are your major symptom/s? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? ☐Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how? _____
4. How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

   How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom?

   ☐ Yes ☐ No If yes, describe: _____

   Are there other unrelated health problems? ☐Yes ☐ No. If yes, describe _____

   _____
6. Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching

   ☐ Burning ☐ Stabbing ☐ Radiating ☐ Other _____
7. Is there anything you can do to relieve the problem? ☐ Yes ☐ No. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
8. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

   ☐ Other Please Describe:_____
9. List any major accidents you have had other than those that might be mentioned above

   _____
10. **WOMEN ONLY**: Are you pregnant or is there any possibility you may be pregnant?

    ☐ Yes ☐ No ☐ Uncertain **First** Day of Last Menstrual Cycle:_____/_____/_____
11. Previous Chiropractic Experience ☐ Yes ☐ No Who?_____
12. Other Medical Professionals Seen for Condition_____
13. Notes: _____

    _____

    _____

    _____

    _____

    _____

NO SYMPTOMS — EXTREME SYMPTOMS

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Please rate yourself 1-10, 1 being no problems and 10 being the worst pain you can imagine.