

# PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND \_\_\_\_\_ FOLLOW AN OBJECT WITH HIS/HER EYES \_\_\_\_\_ HOLD HEAD UP \_\_\_\_\_  
SIT ALONE \_\_\_\_\_ CRAWL \_\_\_\_\_ STAND \_\_\_\_\_ WALK ALONE \_\_\_\_\_

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKENPOX \_\_\_\_\_ MUMPS \_\_\_\_\_ MEASLES \_\_\_\_\_ RUBELLA \_\_\_\_\_  
RUBEOLA \_\_\_\_\_ WHOOPING COUGH \_\_\_\_\_ OTHER \_\_\_\_\_

HAS THIS CHILD EVER SUFFERED FROM:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> HEADACHES            | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS            | <input type="checkbox"/> NECK PROBLEMS       | <input type="checkbox"/> POOR APPETITE       | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> FAINTING             | <input type="checkbox"/> ARM PROBLEMS        | <input type="checkbox"/> STOMACH ACHES       | <input type="checkbox"/> RUPTURES/HERNIA     |
| <input type="checkbox"/> SEIZURES/CONVULSIONS | <input type="checkbox"/> LEG PROBLEMS        | <input type="checkbox"/> REFLUX              | <input type="checkbox"/> MUSCLE PAIN         |
| <input type="checkbox"/> HEART TROUBLE        | <input type="checkbox"/> JOINT PROBLEMS      | <input type="checkbox"/> CONSTIPATION        | <input type="checkbox"/> GROWING PAINS       |
| <input type="checkbox"/> CHRONIC EARACHES     | <input type="checkbox"/> BACKACHES           | <input type="checkbox"/> DIARRHEA            | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> SINUS TROUBLE        | <input type="checkbox"/> POOR POSTURE        | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> SCOLIOSIS           | <input type="checkbox"/> HYPERTENSION        | <input type="checkbox"/> ALLERGIES TO _____  |
| <input type="checkbox"/> COLDS/FLU            | <input type="checkbox"/> WALKING TROUBLE     | <input type="checkbox"/> ANEMIA              | <input type="checkbox"/> OTHER _____         |
| <input type="checkbox"/> COLIC                | <input type="checkbox"/> BROKEN BONES        | <input type="checkbox"/> BED WETTING         | <input type="checkbox"/> OTHER _____         |

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> FALL IN BABY WALKER      | <input type="checkbox"/> FALL FROM BED OR COUCH | <input type="checkbox"/> FALL OFF SKATEBOARD OR SKATES |
| <input type="checkbox"/> FALL FROM CRIB           | <input type="checkbox"/> FALL OFF SWING         | <input type="checkbox"/> FALL OFF BICYCLE              |
| <input type="checkbox"/> FALL FROM HIGHCHAIR      | <input type="checkbox"/> FALL OFF SLIDE         | <input type="checkbox"/> FALL DOWN STAIRS              |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS   | <input type="checkbox"/> OTHER _____                   |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

PRESENT HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERY: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ACCIDENTS: \_\_\_\_\_

FAMILY HISTORY: \_\_\_\_\_

# PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: \_\_\_\_\_ MOTHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MOTHER'S WORK PHONE: \_\_\_\_\_ MOTHER'S CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ FATHER'S WORK PHONE: \_\_\_\_\_ FATHER'S CELL PHONE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ NUMBER OF SIBLINGS: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_ CURRENT LENGTH: \_\_\_\_\_

THIRD TRIMESTER PRESENTATION: VERTEX \_\_\_\_\_ BREECH \_\_\_\_\_ TRANSVERSE \_\_\_\_\_ FACE/BROW \_\_\_\_\_

TYPE OF BIRTH: NORMAL VAGINAL \_\_\_\_\_ FORCEPS \_\_\_\_\_ CESAREAN \_\_\_\_\_ SUCTION CAP OR VACUUM \_\_\_\_\_

LOCATION: HOME \_\_\_\_\_ BIRTHING CENTER \_\_\_\_\_ HOSPITAL \_\_\_\_\_

PROBLEMS DURING PREGNANCY: \_\_\_\_\_

PROBLEMS DURING LABOR/DELIVERY: \_\_\_\_\_

APGAR SCORES: \_\_\_\_\_ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? \_\_\_\_\_ CYANOSIS (BLUE)? \_\_\_\_\_

CONGENITAL ANOMALIES/DEFECTS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN? \_\_\_\_\_

INFANT FEEDING: BREAST \_\_\_\_\_ BOTTLE \_\_\_\_\_ IF BOTTLE, WHICH FORMULA? \_\_\_\_\_

NUMBER OF HOURS SLEEPING PER NIGHT: \_\_\_\_\_ QUALITY OF SLEEP: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR \_\_\_\_\_

OBSTETRICIAN/MIDWIFE: \_\_\_\_\_

PEDIATRICIAN/FAMILY MD: \_\_\_\_\_

DATE OF LAST VISIT: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

IMMUNIZATION HISTORY: \_\_\_\_\_

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS \_\_\_\_\_ DURING HIS/HER LIFETIME \_\_\_\_\_

PREVIOUS CHIROPRACTOR: \_\_\_\_\_

DATE OF LAST VISIT: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? \_\_\_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_

INSURANCE/BILLING INFORMATION: \_\_\_\_\_ POLICY #: \_\_\_\_\_

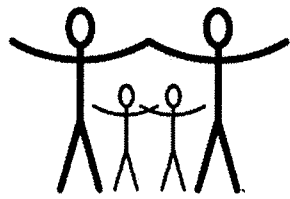
## AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE \_\_\_\_\_

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.  
X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_



# Andrews

## FamilyChiropractic

### CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Andrews Family Chiropractic  
and/or his staff to examine and/or treat my:

\_\_\_\_\_

Indicate Relationship and First Name of Child

Full Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

**INSURANCE FORMS/PAYMENT**

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

*I have read and understand the financial and payment policy of Andrews Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Andrews Family Chiropractic and my insurance company. I request that Andrews Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.*

\_\_\_\_\_  
Patient's signature (or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

*Andrews Family Chiropractic*

**FINANCIAL and PAYMENT POLICY**

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

## PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

## ALL PATIENTS UTILIZING THEIR INSURANCE BENEFITS:

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, co-insurances, or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

## "ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

## PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.

3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

## MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

## SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

## MANAGED CARE PLANS

We are preferred providers for the following companies: United Health Care, Medica, Great West, Blue Plus, Blue Cross Blue Shield (Federal, Minnesota, and out of state plans), Select Care, most Aetna plans, Ucare, and Healthpartners.

## MEDICAID

If you have Medicaid, Blue Plus, or Ucare we are providers for those plans. These plans typically cover one examination per year, x-rays and spinal adjustments. All other services are considered non-covered and are considered your financial responsibility.

**Patient Acknowledgement and Receipt of  
Notice of Privacy Practices Pursuant to HIPAA and Consent  
for Use of Health Information**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_  
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_  
Signature of Parent/Guardian (circle one)