Hoglen Chiropractic & Laser

Pediatric Patient Health History Form

Confidential

Date	Patient ID Number	Code

Patient Information

Name: ______________________

SS#: ______________ Birthdate: __________

Address: ______________________

City: __________ State: ______ Zip: ______

Sex: ☐ M ☐ F Age: ______

Parent / Guardian Name (s): ______________________

Parent Email: ______________________

How did you hear about our office? ______________

Does your child have any siblings? (please include age)

____

Insurance

Do you have Insurance: ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Co.: ______________________

Subscriber Name: ______________________

Subscriber Birthdate: ______________

Relationship to patient: ______________

Do you have a Secondary Insurance: ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Co.: ______________________

Subscriber Name: ______________________

Subscriber Birthdate: ______________

Relationship to patient: ______________

Phone Numbers

Primary Phone: ______________ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

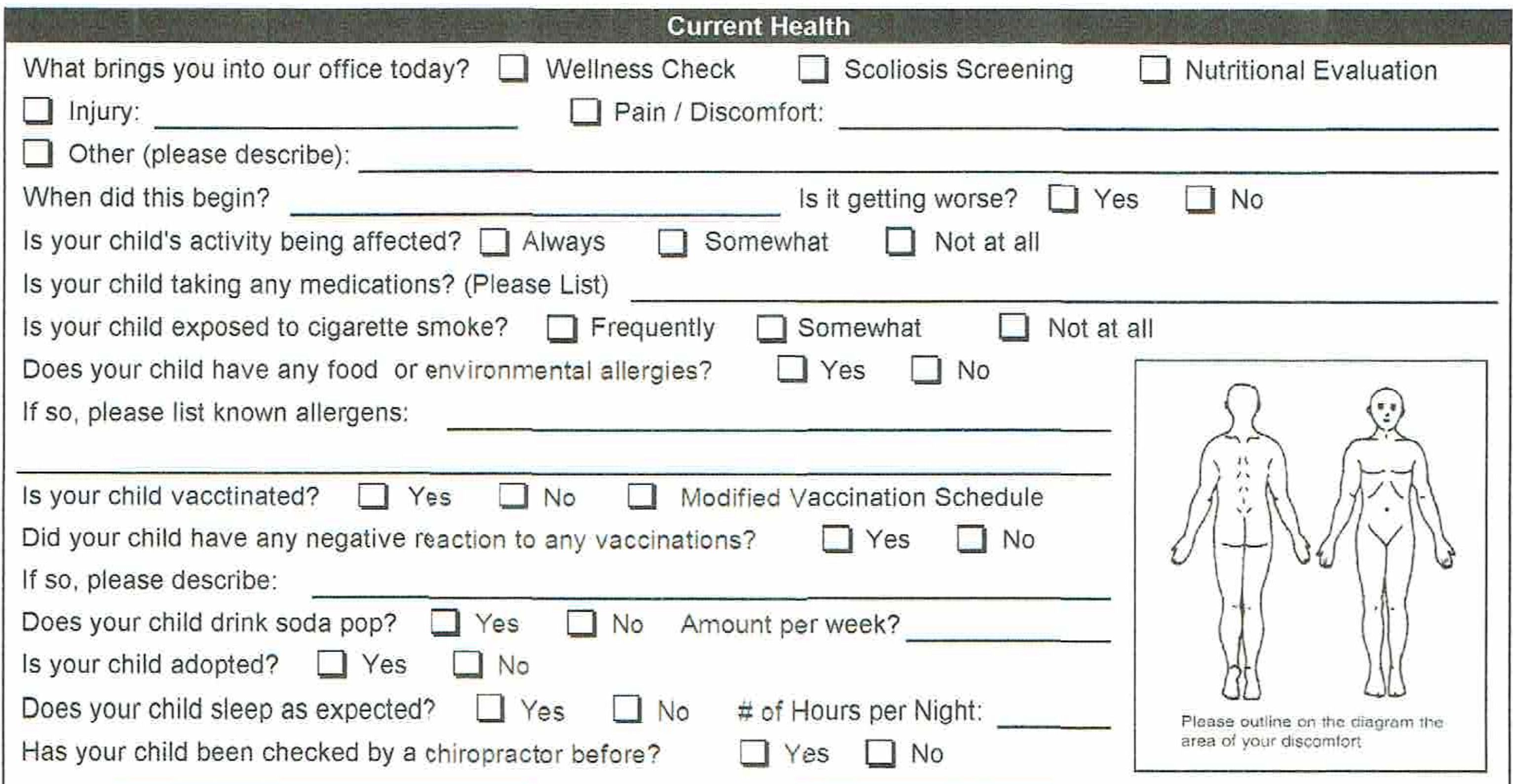
Secondary Phone: ______________ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name of Emergency Contact Person: ______________ Relationship to Patient: ______________

Primary Phone: ______________ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: ______________ ☐ Cellular/Mobile ☐ Home ☐ Work/Business



Current Health

What brings you into our office today? ☐ Wellness Check ☐ Scoliosis Screening ☐ Nutritional Evaluation

☐ Injury: ______________ ☐ Pain / Discomfort: ______________

☐ Other (please describe): ______________________

When did this begin? ______________ Is it getting worse? ☐ Yes ☐ No

Is your child's activity being affected? ☐ Always ☐ Somewhat ☐ Not at all

Is your child taking any medications? (Please List) ______________

Is your child exposed to cigarette smoke? ☐ Frequently ☐ Somewhat ☐ Not at all

Does your child have any food or environmental allergies? ☐ Yes ☐ No

If so, please list known allergens: ______________________

Is your child vacctinated? ☐ Yes ☐ No ☐ Modified Vaccination Schedule

Did your child have any negative reaction to any vaccinations? ☐ Yes ☐ No

If so, please describe: ______________________

Does your child drink soda pop? ☐ Yes ☐ No Amount per week? ______

Is your child adopted? ☐ Yes ☐ No

Does your child sleep as expected? ☐ Yes ☐ No # of Hours per Night: ______

Has your child been checked by a chiropractor before? ☐ Yes ☐ No

Please outline on the diagram the area of your discomfort

Past Health History Information

Please list any Surgery and/or Operations your child has had: ______________________

____

Please list all Accidents or Major Falls your child has had: ______________________

____

Please list any additional Hospitalization (other than above): ______________________

Did your child have any prenatal conditions or complications during the mother's pregnancy? ☐ Yes ☐ No

What was the method of your child's birth & delivery? ☐ Vaginal ☐ C-Section ☐ VBAC

Was there any trauma associated with the birth of your child? ☐ Forceps ☐ Vaccum Extraction ☐ Twisting/Pulling

Was/is your child breast fed? ☐ Yes ☐ No Did/does the child prefer one breast over the other? ☐ R ☐ L

Has your child ever taken antibiotics? ☐ Yes ☐ No How recently was their last dose? ______________

Please Check ANY of the following diseases your child has had:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough

☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox

☐ Diabetes
☐ Cancer
☐ Ear Infections
☐ Thyroid
☐ Influenza

☐ Pleurisy
☐ Jeuvenile Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Meningitis

☐ Eczema

Have you or your child tested HIV Positive? ☐ Yes ☐ No

Please Check ANY of the following conditions, if they have occurred in the past 6 months:

MUSCULO-SKELETAL

☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm pain
☐ Joint Stiffness/Pain
☐ Walking Problems
☐ Difficulty Chewing
☐ Clicking Jaw
☐ General Stiffness

NERVOUS SYSTEM

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

GASTRO-INTESTINAL

☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY

☐ Bladder Trouble
☐ Painful Urination
☐ Excessive Urination
☐ Discolored Urine

GENERAL

☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

EENT

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffy Nose

C-V-R

☐ Chest Pain
☐ Short Breath
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems
☐ Congestion
☐ Ankle Swelling

FAMILY MEDICAL HISTORY

Please check any of the following that have been diagnosed in an immediate family member:

☐ Diabetes
☐ Cancer
☐ Jeuvenile Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Heart Disease
☐ Irregular Heartbeat
☐ Auto-Immune Disorders

Authorization of Care

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 payors 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.

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Complete Wellness Chiropractic Center wants me to know how my Patient Health Information is going to be used in this office and my rights concerning those records. I understand that if I would like to have a more detailed account of this office's policies and procedures concerning the privacy of my Patient Health Information, I may read the HIPAA Notice that is available to me at the front desk before signing this consent.

Printed Name of Authorizing Guardian: ______________________

Guardian's Signature of Authorizing Care: ______________________ Date: ____________