Cloud 9 Chiropractic Pediatric Health History Form

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ SSN: _____

Names of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Birth Date: _____/_____/_____ Sex: _____ Weight: _____ Height: _____

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

HEALTH HISTORY FORM

Purpose for contacting us? _____

Other doctors seen for this condition: ❑Y ❑N Doctors' Names and Prior Treatments: _____

_____

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

❑ Ear Infections	❑ Scoliosis	❑ Seizures	❑ Chronic Colds	❑ Headaches
❑ Asthma/Allergies	❑ ADHD	❑ Recurring Fevers	❑ Colic	❑ Growing/Back Pain
❑ Bed Wetting	❑ Car Accident	❑ Digestive Problems	❑ Temper Tantrums	❑ Other _____

Family History: _____

Previous Chiropractor: _____ Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____ Date of Last Visit: _____ Reason: _____

Are you satisfied with the care which your child has received there? ❑Yes ❑No

Numer of Doses of Antibiotics Your Child has Taken:

During the past six months: _____ Total During his/her lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the past six months: _____ Total During his/her lifetime: _____ List: _____

Vaccination History: _____

Reaction: _____

MOTHER'S PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy? ❑No ❑Yes; List _____

Medications or supplements during pregnancy? ❑No ❑Yes; List _____

Ultrasounds during pregnancy? ❑No ❑Yes; Number _____

Medications (pitocin, epidural, ect.) during delivery? ❑No ❑Yes; List _____

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home ❑ Other _____

MOTHER'S PRENATAL HISTORY - CONTINUED

Birth Intervention: ❑Forceps ❑Vacuum Extraction ❑Caeserian Section: Emergency ❑ Caeserian Section: Planned

Complications during delivery? ❑No ❑Yes; List _____

Genetic Disorders or Disabilities? ❑No ❑Yes; List _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Was delivery within 2 weeks of due date? ❑Yes ❑No; # of days premature/late _____

FEEDING HISTORY

Breast Fed? ❑No ❑Yes How long? _____

Formula Fed? ❑No ❑Yes How long? _____ Type: _____

Introduced to solids at: _____ months; Cow's Milk at _____ months

Food/Juice Allergies or Intolerances? ❑No ❑Yes; List _____

_____

DEVELOPMENTAL HISTORY

During the following times your child is most vunerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound

_____ Respond to Visual Stimuli

_____ Hold Head Up

_____ Sit Up

_____ Cross Crawl

_____ Stand Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child? ❑No ❑Yes

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheer-leading, martial arts, etc.) ❑No ❑Yes; List _____

Has your child ever been involved in a car accident? ❑No ❑Yes; List _____

Has your child been seen on an emergency basis? ❑No ❑Yes; List _____

Other tramas not described above? ❑No ❑Yes; List _____

Prior Surgery: ❑No ❑Yes; List _____

Menarche? ❑No ❑Yes; Age: _____

CHILDHOOD DISEASES

Chicken Pox? ❑No ❑Yes; Age _____

Measles? ❑No ❑Yes; Age _____

Rubella? ❑No ❑Yes; Age _____

Mumps? ❑No ❑Yes; Age _____

Whooping Cough? ❑No ❑Yes; Age _____

Other? _____ ❑No ❑Yes; Age _____

FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

First Visit Fee:
Ages 0-17 Comprehensive Exam: $65.00

Adjustment Fee:
Ages 0-17 Adjustment: $25.00

Please Indicate your method of payment: ❑ Cash ❑ Check ❑ Credit Card

INSURANCE

Insurance converage varies greatly. We cannot predict whether your policy will cover the services we provide **in our office**. Please obtain an **Insurance Verification Form** from our staff, and contact your insurance company to determine the amount and extent of coverage. **Until this form is complete and returned to us, your account will be on a cash basis.**

Please indicate below, the name and policy # of your insurance company:

Health Insurance Company: _____

ONLY if this is an **AUTO ACCIDENT** injury, please provide us with the following information:

Name and policy # of Auto Insurance Company: _____

Have you been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

PLEASE READ AND SIGN BELOW

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give Dr. Erin Jeansonne, D.C. permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I hereby authorize this office and its doctor to administer care for my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to Patient: _____ Date: _____/_____/_____

I understand that any fee for service rendered is due at the time of the service and cannot be deferred to a later date, unless other terms have been agreed upon in writing and that there is a $25.00 fee for all returned checks and missed appointments.

Signature: _____ Today's Date: _____
Signature of Parent (for minor): _____ Today's Date: _____

Thank you for choosing Cloud 9 Chiropractic Wellness Center.
We look forward to helping you.