

Thrive Chiropractic and Wellness

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Pediatric History Form

(12 years of age and under)

Today's Date ____/____/____

Name _____ Date of Birth ____/____/____ Social Security # ____ - ____ - ____

Address _____ City _____ State ____ Zip _____

Phone (H) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Purpose of last visit: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? No Yes: Who/When? _____

Who is responsible for this bill? Mother Father Other (please explain) _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: Vertex Breech Transverse Face/Brow

Type of Birth: Normal Vaginal Forceps Cesarean Suction Cap or Vacuum

Location: Home Hospital Birthing Center Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: Jaundice? (yellow) Cyanotic? (blue) Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: Breast Bottle If Bottle; which formula? _____

Number of Hours sleep per night ____ Quality of Sleep: Good Fair Poor

List date of most recent **IMMUNIZATIONS** your child has had: _____

Did they have a negative reaction: Yes No If yes please explain: _____

I do NOT immunize my child(ren) I would like more information on Philosophical or Religious Exemptions that allow me NOT to immunize my child.

Has your child ever been treated at the emergency room? Yes No If yes; please explain: _____

Has your child ever been hospitalized? Yes No If yes; please explain: _____

Has your child ever had any surgeries? Yes No If yes; please explain: _____

Is your child currently on any medications? Yes No If yes; please list: _____

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 CHILD SUFFER FROM THE FOLLOWING:

Chicken pox ____ Mumps ____ Measles ____ Rubella ____ Whooping Cough ____

Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

- Headaches
- Dizziness
- Fainting
- Seizures/Convulsions
- Heart Trouble
- Chronic Earaches
- Sinus Trouble
- Asthma
- Colds/Flu
- Colic
- Orthopedic Problems
- Neck Problems
- Arm Problems
- Leg Problems
- Joint Problems
- Backaches
- Poor Posture
- Scoliosis
- Walking Trouble
- Broken Bones
- Digestive Disorders
- Poor Appetite
- Stomach Aches
- Reflux
- Constipation
- Diarrhea
- Hypertension
- Anemia
- Bed Wetting
- Sleeping Problems
- Behavioral Problems
- ADD/ADHD
- Ruptures/Hernia
- Muscle Pain
- Growing Pains
- Allergies to _____
- Allergies to _____
- Allergies to _____
- Other: _____
- Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- Fall in baby walker
- Fall off swing
- Fall down stairs
- Fall from bed or couch
- Fall off bicycle
- Fall from changing table
- Fall off skateboard or skates
- Fall from high chair
- Fall off monkey bars
- Fall from Crib
- Fall off Slide
- Other: _____

Has your child ever sustained an injury playing organized sports? Yes No If yes; please explain: _____

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

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- _____ Heart Disease _____ Diabetes _____ Stroke _____ Cancer _____ High/Low Blood Pressure
- _____ Asthma _____ Gastrointestinal disease _____ Memory/mood disorder _____ Thyroid problem

CHILD'S CURRENT PROBLEM:

- Purpose of this visit:**
- Wellness Check-up Other: _____
 - Pain/Discomfort; explain _____
 - Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ___/___/___ Unknown Gradual Sudden
2. **Ever had** this problem **before**? No Yes If yes; when? _____
3. Any **bowel or bladder** problems since this problem began? No Yes If yes; when? _____
4. Any **medication taken** for this problem? No Yes If yes; when? _____
5. Have you seen any **other doctors** for this problem? No Yes If yes; when? _____
6. How is this problem **NOW**: Rapidly Improving Improving Slowly About the same Gradually Worsening On and Off

General Consent Form: The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicated honestly with Dr. Powell or Dr. Gentilini, and to notify him/her of any changes in health status.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred. I hereby assign my major medical insurance benefits, including Medicare, private insurance, and other health plans to Thrive Chiropractic and Wellness. Any overpayment will promptly be refunded. I also authorize Thrive Chiropractic and Wellness to release any protected health information required to secure payment.

HIPAA Privacy Practices: I understand that a copy of my HIPAA rights is available to me upon request.

Responsible Party's Signature: _____ **Date** ___/___/___