Today's Date _____/_____/_____

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

Thrive Chiropractic and Wellness
Nathan Kronemeyer, D.C.
1190 Bridge St., Brighton CO 80601
303.659.4220 / staff@thrivechiropractic.com

Pediatric History Form
(10 years of age and under)

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 _____
ID Number _____ Group Number_____
Primary Policy Holder: Name _____ Date of Birth ____/____/_____

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? ☐Cyanocic? ☐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:_____
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 _____

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 _____ Thyroid problem
_____ Gastrointestinal disease _____ Memory/mood disorder

HAS YOUR CHILD EVER SUFFERED FROM:

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

Has your child ever suffered a major fall or spinal trauma? ☐Yes ☐No
If yes; please explain: _____

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: _____

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:

Onset of Problem: Date ___/___/___ ☐Unknown ☐Gradual ☐Sudden
Ever had this problem **before**? ☐Yes ☐No If yes; when?_____
Any **bowel or bladder** problems since this problem began? ☐Yes ☐No If yes; when? _____
Any **medication taken** for this problem? ☐Yes ☐No
If yes; what was taken and when? _____
Have you seen any **other doctors** for this problem? ☐No ☐Yes If yes; when?_____
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 request for release of my records must be in writing. Protected health information will be released with written authorization, with the 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. Kronemeyer, and to notify him 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.

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize Thrive Chiropractic and Wellness and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

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