Pediatric Initial Information

CONTACT INFORMATION:

Child's Name: ____

Mother's Name: ______________________________ Father's Name: __________________________________

Address: ____

City: _______________________ State: __________ Zip: __________

Mother's Home/Cell: ___________________________ Father's Home/Cell: ______________________________

Fathers Email: ______________________________ Mothers Email: ____________________________________

Obstetrician/Midwife:

____

Name Location Phone #

Pediatrician/Family MD:

____

Name Location Phone #

Date of Last Visit ________________

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: ____ Date of Birth: _____/______/______ Gender: **M F**

Reason for this visit:

____

Age: ________ Birth Weight: _______ Current Weight: ________ Birth Length: ________ Current Length: ________

# of Siblings: ______

Childs Congenital Anomalies/Defects:

____

Family History of Congenital Anomalies/Defects:

____

Type of Birth (circle all that apply): **Normal Vaginal** **Forceps** **Suction** **Breech** **Cesarean** **Cord around neck**

Birthing Location: Home Birth Birthing Center: ______________________ Hospital: ________________________

Pregnancy History / Problems during Pregnancy:

____

____

Delivery & Birth History / Problems during Labor & Delivery:

____

____

APGAR Scores: _________ Was there presence at birth of: ____ Jaundice (yellow) ____ Cyanosis (blue)

Infant Feeding: Breast: **Y N** # of Months: _________ Bottle: **Y N** # of Months: _________

Formula: **Y N** # of Months: _________ Brand(s): ____

Number of Hours of Sleep Per Night: __________ Quality of Sleep (circle): **Good** **Fair** **Poor**

Immunization History:
____
____

Developmental History - At what age did the child:

Respond to sound _________ Sit unaided ________ Follow an object with his/her eyes _______ Hold head up _________
Walk unaided _________ Crawl __________ Stand unaided _________

Childhood Diseases your child may have had: **(check all that apply)**
Chicken Pox ______ Mumps ______ Measles ______ Whooping Cough _______ Rubella ________
Other:____
Has this child ever suffered from: **(check all that apply)**
_____ Dizziness _____ Bed wetting _____ Tuberculosis _____Blood Disorders _____ Chronic earaches _____ Diabetes

_____ Digestive Disorders _____ Headaches _____ Heart trouble _____ "Growing pains" _____Arthritis _____ Fainting

_____ Hyperactivity _____ Hypertension _____ Allergies ______ Neuritis _____ Neck problems _____ Convulsions

_____ Asthma _____ Constipation _____ Anemia _____ Joint problems _____ Rheumatic Fever _____ Sinus trouble

_____ Diarrhea _____ Poor appetite _____ Backaches _____ Arm problems _____ Walking problems _____ Paralysis

_____ Behavioral problems _____ Broken bones _____Leg problems _____ Muscle jerking _____ Colds/Flu

______Stomach Aches ______Ruptures/Hernias

Other: ____

Present History & Allergies:
____
____
____

Surgeries:
____

Accidents, Falls or Traumas:
____
____

Medications:____

Family History:
____
____
____

Anderson
INTEGRATED HEALTH CENTER

INSURANCE INFORMATION:
Primary Secondary (if applicable)

Who is responsible for this account? ____

Relationship to Patient: ____

Insurance Co: ____

ID Number: ____

Group #: ____

ASSIGNMENT & RELEASE – PLEASE NOTE: YOU MUST SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE
I, the undersigned certify that my dependant has insurance coverage with ____________________________ and assign directly to Dr. Anderson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions..

____/ ______________________/ ______/______/_______
Responsible Party Signature **Relationship to Patient** **Date**

AUTHORIZATION FOR CARE OF A MINOR
Chiropractic examination and Chiropractic care including but not limited to spinal adjustments. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.
I HEREBY AUTHORIZE Anderson Specific Chiropractic INC. AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

____/______________________/ ______/____/_________
PARENT / GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**