Date: _____ / _____ / _____

duncan chiropractic group

Pediatric History Form

Patient Name_____ Date of Birth____ /____ /____ Age_____ Male / Female

Address_____City_____State_____ Zip_____

Guardian(s) Name:_____ Relationship:_____

Phone Number:_____ Email: _____

Who may we thank for referring you?_____

What are your chief concerns, if any, with your child's health?

_____

_____

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____

Results?_____

History of Complaint

Date of Onset (mm/yyyy): _____

Onset was: (circle one)
Sudden Gradual Associated with an event

Duration of problem or episode: (circle one)
Minutes Hours Days Months Years

Pattern of Problem: (circle one)
Constant Intermittent Occasional Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body functions and daily activities?

_____

Previous episodes of this problem? _____

Present prescription drugs/ dosage?_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years: _____

Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

Complete page 2 if patient is under 1 year of age

Pregnancy Information:

How was your pregnancy? _____

Any pregnancy complications? _____

Other information: _____

Delivery Information:

Birth Intervention: (Circle all that apply) Forceps Vacuum Extraction Caesarian Section None

Other information: _____

Post Birth Information:

Birth Weight:_____ Birth Length: _____

Breast Fed: Yes / No How long?_____ Formula Fed Yes / No How Long?_____

Introduced Solid Foods at _____ Months

ACTIVITY:	COMPLAINTS EFFECT ON:			
Holding Head Up	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Tummy Time	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Nursing	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Sitting Up	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Crawling	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Standing Alone	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Walking Alone	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Other: _____	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform
Other: _____	○ Does Often	○ Does Occasionally	○ Does Rarely and/or Cries During	○ Unable to Perform

Insurance Information

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Insurance Company(ies)
assign directly to Duncan Chiropractic Group 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 by insurance. I authorize the use of my signature on all insurance submissions.

Duncan Chiropractic Group may use my health care information and may disclose such information the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Parent, Guardian or Personal Representative: _____

Please print name of Parent, Guardian, or Personal Representative: _____

Date: _____ *Relationship to Patient:* _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ *Date:* _____

Consent for Treatment of a Minor

I _____ **(Parent or Legal Guardian)**, hereby give the consent to the rendering care, including diagnostic procedures, x-rays and treatment given by the physicians at Duncan Chiropractic Group for _____ **(Patient Name)**. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Duncan Chiropractic Group.

Guardian Signature: _____ *Date:* _____

Relationship To Minor/Child: _____

Witness to Signature: _____