Pediatric History Form

Dear New Patient,

It is a 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 a better health for your family.

Patient Name: ______________________________ S.S.# ________________

Address: ______________________________ City: ________________

State: ________ Zip: ____________ Home Phone: ____________ Cell : ____________

Birth Date: _____/_____/_____ Work Phone: ____________________

Sex: _____ Weight: _______ Height: _______ Referred by: ________________

Names of Parents / Guardians: ______________________________

Purpose For Contacting Us?

____

Other Dr's seen for this condition: ______________________________

Prior treatments given for this condition: ______________________________

Other Health Problems: ______________________________

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

- ☐ Ear Infections
- ☐ Scoliosis
- ☐ Seizures
- ☐ Chronic Colds
- ☐ Headaches
- ☐ Colic
- ☐ Asthma/Allergies
- ☐ Digestive Problems
- ☐ ADHD
- ☐ Recurring Fevers
- ☐ Car Accident
- ☐ Growing/Back Pains
- ☐ Bed Wetting
- ☐ Temper Tantrums
- ☐ Other ______________________________

Previous Chiropractor: ______________________________ Date of Last Visit ____________

Name of Pediatrician: ________________________________ Date of Last Visit ____________

Reason for Visit: _____________________________

Are You Satisfied With The Care Your Child Has Received?: ___ No ___ Yes

Number of Doses of Antibiotics Your Child Has Taken: _____ Last Six Months _____ Lifetime

Vaccination History: ☐ Current ☐ Not Current

Prenatal History:

Name of Obstetrician / Midwife:

____

Complications During Pregnancy? ___No ___ Yes, List ______________________________

Ultrasounds During Pregnancy? ___ No ___ Yes, Number __________

Medication During Pregnancy? ___ No ___ Yes, List ______________________________

Cigarette / Alcohol Use During Pregnancy? ___ No ___ Yes

Type of Birth: (check all that apply)

☐ Normal Vaginal ☐ Epidural ☐ Forceps ☐ Suction ☐ Breech

☐ Cesarean ☐Home Birth ☐ Hospital Birth

Birth Weight _______ Birth Length _______ APGAR Scores: _______; _______

Feeding History:

Breast Fed: ______ No ______ Yes, How Long? ________________

Formula Fed: ______ No ______ Yes, How Long? ______________ Type? ____________________

Developmental History:

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, down stairs, etc.). Was this the case with your child?

☐ Yes ☐ No

Is / Has your child been involved in any high impact or contact sports? (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Etc.) ____No ____ Yes, List:

____

____

Has your child ever been in a car accident? ____ No ___ Yes

List ____

Has you child ever been seen on an emergency basis? ___No ___ Yes

List ____

Prior Surgery: ____

Menarche: _____ No _____ Yes Age__________

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to 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: ______________________________ Date: ______________

Patient Name: ______________________

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

____

Patient's Signature **Date**

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Patient's Name: ______________________

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes. I am definitely pregnant.
- ☐ No. I am definitely not pregnant at this time.

Date of last menstrual period: ______________________

____

Patient's Signature **Date**

Patient Acknowledgement and Receipt of Notice of Privacy Practices to HIPPA and Consent for Use of Health Information

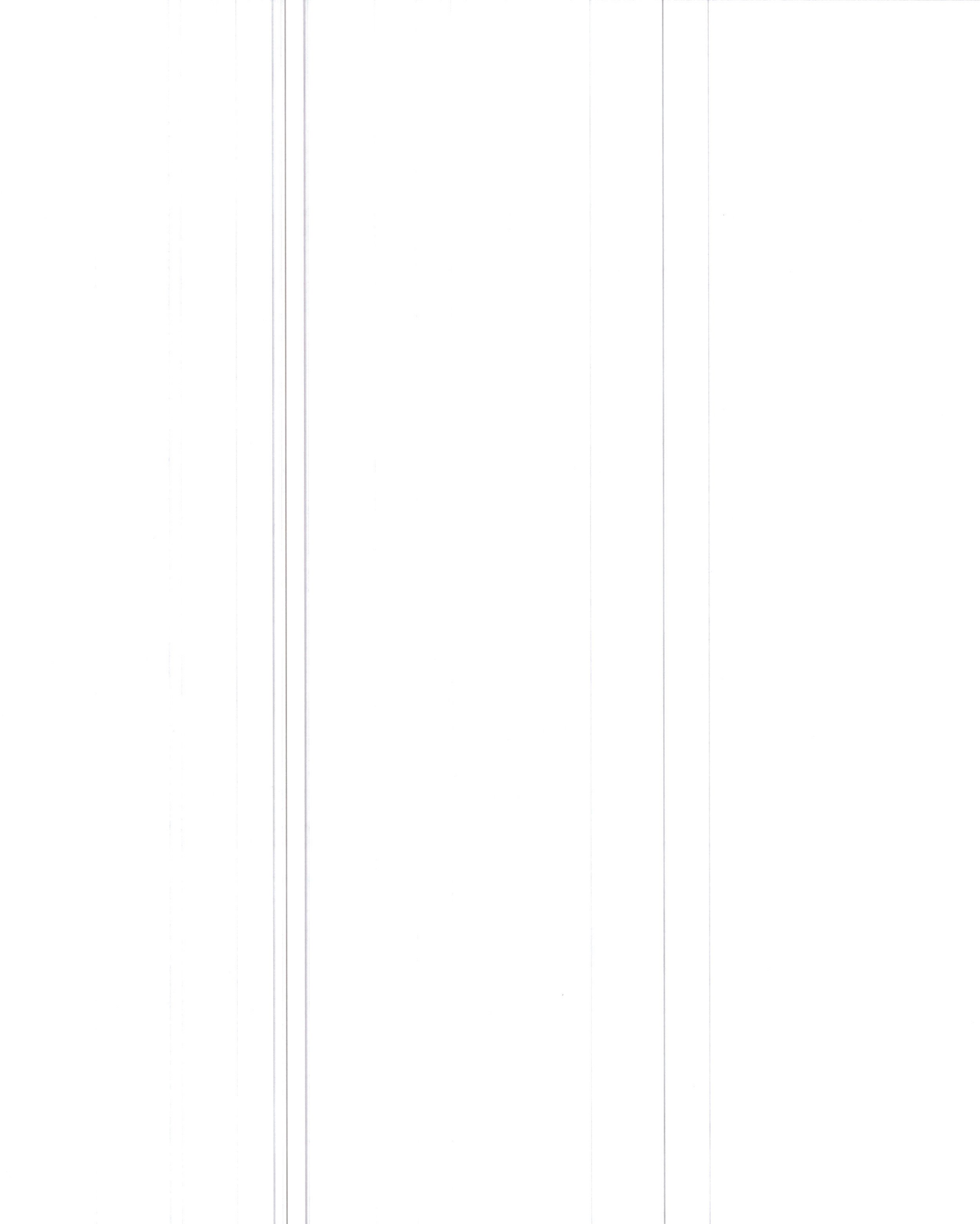
The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State and Federal Law.

If patient is a minor or under a guardianship order as defined by State law:

____

Patient's/Guardian's Signature



Synergy Chiropractic Center
Card Authorization

Please Read Carefully

As high deductible plans have become much more popular, we have a significant percentage of patient bills that are not being paid. Like all businesses, we cannot function without payment for our services. We are a small practice and rely on prompt payments to cover our daily overhead.

As of June 1, 2022, we will be asking you for a credit card, debit card or health savings card to keep on file. The number will be stored by a secure bank server. If a patient bill, (not an insurance bill) has not been paid within 30 days of receipt, we will charge your card for that patient balance. If you wish to dispute the charge, wish to be placed on a payment plan, or would like us to use another card **please contact us promptly upon receiving the bill.** We understand that some patients have financial hardship, and we do not wish to make that worse. We will always work with patients to establish a fair payment plan if needed. Please speak to your doctor if you want to obtain further information about payment plans.

I authorize Synergy Chiropractic Center to charge my card ending in __________ for all outstanding patient billed charges if they are not paid in full within 30 days of receiving a bill

Printed name______________________________________

Signature ______________________________________ Date __________

Child / Children

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________