**Pediatric History Form**

Today’s Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_

Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardian Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insureds name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insureds date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Phone Number Cell # - email-

Child’s Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender\_\_\_\_

Who can we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chiropractic Care? Y N Prior Doctor of Chiropractic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check reasons for pursuing chiropractic care for your child:**

\_\_\_ I Recently had my spine checked and I see the value in getting my child checked.

\_\_\_ I’m concerned about his/her health and I’m looking for answers.

\_\_\_ She /He has a specific condition that concerns me.

**Explain condition of symptom:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_I want to improve my child’s immune function.

\_\_\_I have no idea why we’re here. Please take the time to explain to me what you do for children.

**In order for us to better understand your child’s current level of health, please check any of the**

**following body signals which your child has or has had previously:**

\_\_\_Headache \_\_\_Postural Imbalance \_\_\_Asthma \_\_\_Ear Infection

\_\_\_Scoliosis \_\_\_ADD/ADHD \_\_\_PDD/Autism \_\_\_Seizures

\_\_\_Growing/Back Pain \_\_\_Car Accident \_\_\_Digestive Problems \_\_\_Colic

\_\_\_ Frequent Colds \_\_\_Sinus Problems \_\_\_Bedwetting \_\_\_Sleep Disorders

**Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List Prescription or Over the Counter Medications Currently Taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of doses of **Antibiotics** your child has taken:

During the past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of doses of other **Prescription Medications** taken:

During the past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total during her/his lifetime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal History:

Adopted? \_\_\_\_No \_\_\_Yes

Complications during pregnancy? \_\_\_No \_\_\_Yes

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasounds during pregnancy? \_\_\_No \_\_\_Yes

How Many? \_\_\_\_\_\_\_

Medications/drugs/caffeine during pregnancy? \_\_\_\_No \_\_\_Yes

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette/Alcohol use during pregnancy? \_\_\_No \_\_\_Yes

Location of Birth: \_\_\_Hospital \_\_\_Birthing Center \_\_\_Home

Birth Intervention: \_\_\_All Natural/Mother Induced \_\_\_Mother Medicated (Pitocin, etc.)

\_\_\_Caesarean Section \_\_\_Forceps \_\_\_Vacuum Extracted

\_\_\_ Baby given medication after delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications during delivery: \_\_\_No \_\_\_Yes

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic Disorders or Disabilities? \_\_\_No \_\_\_Yes

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Fed? \_\_\_No \_\_\_Yes How Long? \_\_\_\_\_\_\_ Formula Fed? No \_\_\_Yes How Long?\_\_\_\_\_

Food Allergies or Intolerances? \_\_\_No \_\_\_Yes

List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during

the first year of life (I.E., a bed, changing table, downstairs, etc.). Was this the case with your child? \_\_\_No \_\_\_Yes

Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is/Has your child been involved in any high impact or contact type sports (I.E., soccer, football, gymnastics,

hockey, baseball, cheerleading, martial arts, basketball, etc.)? \_\_\_No \_\_\_Yes

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been seen on an Emergency Basis? \_\_\_No \_\_\_Yes

List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Surgery? \_\_\_No \_\_\_Yes

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body’s internal wisdom. Our only method is specific adjusting to

correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_

(Parent/Guardian Signature) (Date)

NEW BEGINNINGS CHIROPRACTIC DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1820 N. TYLER RD

WICHITA, KS 67212 NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future work at the clinic or office listed on this page.

I have/or will have the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am now informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

**Patient Responsibility**

I understand and agree that I am financially responsible for all charges for all services rendered. This includes any medical service or visit, adjustment, therapy, and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm benefits, confirmation of benefits is not a guarantee of payments and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain a referral. I understand that without this referral, my insurance will not pay for any services and that I am financially responsible for all services rendered.

I agree to inform the office of any changes to my insurance coverage. If my insurance changes or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I have read, or have had read to me, the above consent. I understand I have the opportunity to ask questions about this consent and its content prior to treatment and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

By signing this form, I consent to the use and disclosures of protected health information about me or treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. New Beginnings Chiropractic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

PATIENT’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Written Acknowledgment of Doctor’s Notice of Privacy Practices:**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received a copy of New Beginnings Chiropractic’s Notice of Privacy Practices.