Chiropractic Pediatric Case History Form

(Newborn to 17 years of age)

PERSONAL INFORMATION

NAME:_____ _____ _____

(LEGAL FIRST) (MI) (LEGAL Last)

ADDRESS: APT NO./SUITE

CITY: STATE/ZIP CODE:

FATHERS NAME: MOTHERS NAME:

PHONE NUMBERS: FATHER ____-____-____ MOTHER ____-____-____

DATE OF BIRTH: AGE: YEARS MONTHS

SOCIAL SECURITY NUMBER: (CIRCLE ONE)

MALE FEMALE

LEGAL GAUDIAN(S) (If other than parents): WHO IS RESPONSIBLE FOR THE BILL: (circle)

PARENT(S) (GAURDIAN) / PERSONAL INJURY

HEALTH INSURANCE COMPANY NAME (if applicable):

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ INSURED'S SSN: _____

BIRTH HISTORY

DELIVERY METHOD (check all that apply): ❑ VAGINAL ❑ FORCEPS ❑ VACUUM EXTRACTION/SUCTION ❑ CAESAREAN SECTION ❑ MEDICATION DURING PREGNANCY OR DELIVERY

WAS MOTHER UNDER CHIROPRACTIC CARE DURING PREGNANCY ❑ YES ❑ NO

ANY COMPLICATIONS DURING THE PREGNANCY OR THE DELIVERY? ❑ YES ❑ NO

PLEASE EXPLAIN:

ANY KNOWN CONGENITAL ANOMALIES/DEFECTS ❑ YES ❑ NO

PLEASE EXPLAIN:

VITAL HEALTH INFORMATION

CURRENT WIEGHT:

CURRENT HIEGHT/LENGTH:

DO YOU NOTICE ANY DEVELOPMENTAL DELAYS IN YOUR CHILD? ❑ YES ❑ NO

PLEASE EXPLAIN:

PAST HEALTH INFORMATION

FAMILY DOCTOR/PEDIATRICIAN

DR'S NAME_____ CLINIC NAME/LOCATION_____

DATE OF LAST VISIT

HAS YOUR CHILD HAD CHIROPRACTIC CARE IN THE PAST? ❑ YES ❑ NO

IF YES, WHERE DID YOUR CHILD RECEIVE CHIROPRACTIC CARE? _____

DATE OF LAST ADJUSTMENT:

HAS YOUR CHILD EVER BEEN IN AN AUTO ACCIDENT? ❑ YES ❑ NO

IF YES, APPROXIMATE DATE: _____

DESCRIBE INCIDENT:

HAS YOUR CHILD HAD ANY OTHER MAJOR INJURIES, FALLS, HEAD INJURIES, OR ACCIDENTS?

❑ YES ❑ NO DATE OF INCIDENT:_____

DESCRIBE INCIDENT: _____

_____

DATE OF INCIDENT: _____

DESCRIBE INCIDENT:_____

_____

HAS YOUR CHILD HAD ANY BROKEN BONES OR DISLOCATIONS? ❑ YES ❑ NO

PLEASE EXPLAIN: _____

HAS YOUR CHILD EVER BEEN INVOLVED IN OR IS CURRENTLY INVOLVED IN ANY HIGH IMPACT OR CONTACT SPORTS (WRESTLING , SOCCER, FOOTBALL, GYMNASTICS, MARTIAL ARTS…)

❑ YES ❑ NO

PLEASE LIST SPORTS:

HAS YOUR CHILD EVER HAD ANY SURGICAL OPERATIONS? ❑ YES ❑ NO

DATE OF OPERATION(S):

REASON FOR OPERATION(S):

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❑ YES ❑ NO

DATE OF HOSPITALIZATION:

REASON FOR HOSPITALIZATION?

FOR DOCTORS USE ONLY

CONTRAINDICATIONS FOR ADJUSTMENTS:

ACUTE ARTHROPATHIES **Y / N**

ACUTE FRACTURE/DISLOCATION WITH INSTABILITY **Y / N**

UNSTABLE OS ODONTOIDEUM **Y / N**

MALIGNANCIES IN VERTEBRAL COLUMN **Y / N**

INFECTION OF BONE OF VERTEBRAL COLUMN **Y / N**

SIGNIFICANT MAJOR ARTERY ANEURYSM NEAR AREA OF MANIPULATION **Y / N**

"The doors we open and close each day decide the lives we live."

HEALTH HABITS

PLEASE CHECK ANY OF THE BELOW HABITS YOUR CHILD HAS:

❑ JUNK FOOD	❑ HEALTHY FOOD
❑ POP/ HIGH SUGAR FRUIT DRINK INTAKE	❑ HIGH ACTIVITY LEVEL/EXERCISE
❑ EXCESSIVE TELEVISION/COMPUTER/ VIDEO GAMES	❑ LOW ACTIVITY LEVEL/EXERCISE
❑ DIFFICULTY IN SCHOOL/LACK OF FOCUS	❑ STRESS
❑ SMOKING	❑ DRINKING

FAMILY/PAST HISTORY

CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT YOU OR ANYONE IN YOUR FAMILY HAS EXPERIENCED IN THE PAST **AND LIST IF IT IS YOU OR A RELATIVE WHO WAS AFFECTED**

CANCER: _____

HIGH BLOOD PRESSURE: _____

LOWER BACK: _____

HEART DISEASE: _____

NECK PAIN: _____

STROKE: _____

HEADACHES: _____

MEDICATIONS / SUPPLEMENTS

PLEASE PROVIDE ANY NUTRITIONAL SUPPLEMENT , OVER THE COUNTER MEDICATION, OR PERSCRIPTION MEDICATION TAKEN BY YOUR CHILD IN THE LAST YEAR. **PLEASE INCUDE VACCINATIONS AND ANTIBIOTICS.**

Supplement/Medication Name	Amount Taken (mg)	How long I've been taking it	Reason for Supplement/Medication
1.			
2.			
3.			
4.			
5.			

NOTES:

CURRENT HEALTH STATUS 1

REASON WHY YOUR CHILD IS HERE: ❑ WELLNESS CHECK ❑ SPECIFIC CONDITION
PLEASE DESCRIBE THE FIRST CONDITION (ROOM FOR ADDITIONAL CONDITION BELOW)
WHEN DID THIS CONCERN BEGIN?
IS THIS CONCERN DUE TO AN ACCIDENT OR A SPECIFIC EVENT/INCIDENT? ❑ YES ❑ NO PLEASE EXPLAIN:
HOW LONG HAS THIS CONDITION BEEN BOTHERING YOUR CHILD? ❑ 1 WEEK ❑ 2-7 WEEKS ❑ 2-4 MONTHS ❑ GREATER THAN 4 MONTHS
HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HOW OFTEN DOES THIS CONCERN BOTHER YOUR CHILD? (PLEASE CHECK ONE) ❑ DAILY: NUMBERS PER DAY_____ ❑ WEEKLY: NUMBERS PER WEEK_____ ❑ MONTHLY: NUMBER PER MONTH _____
HAS YOUR CHILD SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO
TYPE OF TREATMENT:
HAS YOUR CHILD EVER HAD SIMILAR CONDITIONS IN THE PAST? ❑ YES ❑ NO
THIS CONDITION IS: ❑ GETTING WORSE ❑ STAYING THE SAME ❑ IMPROVING
IS THIS CONDITION INTERFERING WITH: ❑ SCHOOL ❑ SLEEP ❑ CONCENTRATION ❑ DAILY ROUTINE
DO ANY PARTICULAR ACTIVITIES OR MOVEMENTS AGGRAVATE THIS CONDITION?

CURRENT HEALTH STATUS 2

REASON WHY YOUR CHILD IS HERE: ❑ WELLNESS CHECK ❑ SPECIFIC CONDITION
PLEASE DESCRIBE THE FIRST CONDITION (ROOM FOR ADDITIONAL CONDITION BELOW)
WHEN DID THIS CONCERN BEGIN?
IS THIS CONCERN DUE TO AN ACCIDENT OR A SPECIFIC EVENT/INCIDENT? ❑ YES ❑ NO PLEASE EXPLAIN:
HOW LONG HAS THIS CONDITION BEEN BOTHERING YOUR CHILD? ❑ 1 WEEK ❑ 2-7 WEEKS ❑ 2-4 MONTHS ❑ GREATER THAN 4 MONTHS
HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HOW OFTEN DOES THIS CONCERN BOTHER YOUR CHILD? (PLEASE CHECK ONE) ❑ DAILY: NUMBERS PER DAY_____ ❑ WEEKLY: NUMBERS PER WEEK_____ ❑ MONTHLY: NUMBER PER MONTH _____
HAS YOUR CHILD SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO
TYPE OF TREATMENT:
HAS YOUR CHILD EVER HAD SIMILAR CONDITIONS IN THE PAST? ❑ YES ❑ NO
THIS CONDITION IS: ❑ GETTING WORSE ❑ STAYING THE SAME ❑ IMPROVING
IS THIS CONDITION INTERFERING WITH: ❑ SCHOOL ❑ SLEEP ❑ CONCENTRATION ❑ DAILY ROUTINE
DO ANY PARTICULAR ACTIVITIES OR MOVEMENTS AGGRAVATE THIS CONDITION?

Review of Health Systems

Has your Child ever suffered from: (check all that apply)

General

__Headaches/Migraines

__Convulsions/Epilepsy

__Tremors

__Loss of Balance

__Dizziness/Vertigo

__Fainting

__Sleeping Problems

__Colic

__Cold Sweats

__Weight Problems

__Loss or gain of a significant amount of weight within 6 months

__Jaw/TMJ Problems

__Ruptures/Hernias

Ears, Eyes, Nose, Throat

__Frequent Colds/Flu

__Blurred Vision R/L

__Double Vision R/L

__Ear Infection

__Loss of smell

__Buzzing/Ringing in Ears

__Sinus Problems

__Allergies

__Recurrent Ear Infections

__Tooth Abscess

__Difficulty Hearing

Respiratory System

__Asthma

__Chronic Cough/Cold

__Difficulty Breathing

__Pain W/ Cough/Sneeze

__Shortness of Breath

__Lung Problems

__Recurring Infections

__Sinus Problems

Emotional/Mental

__Nervousness/Anxiety

__Unexplained Fatigue

__Depression

__Irritability/Mood Swings

__Tension/Stress

__Behavioral Issues

__Hyperactivity

Musculoskeletal System

__"Growing" Pains

__Neck Stiffness/Pain

__Mid-Back /Rib Stiffness/Pain

__Low Back Stiffness/Pain

__Hip Pain R/L

__Fractured Bones

__Swollen Painful Joints

__Muscle Problems

__Difficulty Walking

__Scoliosis

__Shoulder/Elbow Problems

__Wrist/Hand Problems

__Knee/Ankle/ Foot Problems

Nervous System

__Numbness/Tingling/Pain in (Arm/Hands/Fingers)

__Numbness/Tingling/Pain in (Buttocks/Thighs/Legs/ Feet/Toes)

__Cold Hands

Reproductive System

__Urinary Tract Infections

__Pelvic Pain

MALES ONLY:

__Prostate/Sexual Dysfunction

FEMALES ONLY:

__Menstrual Cramping

__Menstrual Irregularity

__Vaginal Pain/Infection

__Breast Pain/Lumps

Age of first menstrual period:

_____

Date of last menstrual period:

_____

Is there any chance the patient might be pregnant?

_____Yes _____No _____Not Sure

Serious Illness/Disease

__Chicken Pox (Age:____)

__Measles (Age:____)

__Mumps (Age:____)

__Rubella (Age:____)

__Whooping Cough (Age:____)

__Rubeola (Age:____)

__HIV/AIDS (Age:____)

__Cancer (Age:____, Type:_____)

__Thyroid Problems

__Liver Trouble/Hepatitis

__Kidney Problems

__Diabetes Type I or II

__Other:_____ (Age:____)

Cardiovascular System

__Diabetes Type I or II

__High Blood Pressure

__Chest Pain

__Heart Problems

__Anemia

Integumentary System

__Skin Problems

__Rashes

__Hives

__Skin Sensitivity

__Easy Bruising

Genito-Urinary System

__Recurring Infections

__Difficulty Urinating

__Bed Wetting

Gastro-Intestinal System

__Gall Bladder Problems

__Digestive Problems

__Stomach Upset

__Heartburn/Reflux

__Diarrhea/Constipation/Gas

__Poor Appetite

__Food Allergies or Intolerances

***X-rays may be taken during the exam & x-rays can damage fetal development.**

Signature of guardian verifying patient is NOT pregnant:

_____

Other:

_____

_____

_____

_____

_____

AUTHORIZATION FOR CARE AND INFORMED CONSENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mouw Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to Mouw chiropractic will be credited to my account. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I further understand that if payment is not collected in a timely manner I may be subject to collections means and/or interest payments of 14%.

Medicare/Medicaid Patient Certification and Payment Request. I certify that the information given by me in applying for the payment under Title XIX and/or Title XI of the SSA, is correct.

Assignment of Benefits. I hereby assign payment directly to the physician accepting the assignment of medical benefits to my health insurance applicable and otherwise payable to me but not to exceed the physician's regular charges. If my care is the result of an auto accident, I authorize the benefits of my auto insurance medical payment's policy to be made directly to Mouw Chiropractic for services related to that auto accident and the remaining balance, if any/ may be submitted to my health insurance coverage.

I have read the above statement and fully understand the above terms of acceptance and hereby authorize this office and its doctors to administer care to my daughter/son as they deem necessary. Risks are minimal but you should be aware of other treatment options including: self-administered over the counter analgesics, rest, medical care, prescription drugs. There are risks and benefits of such options which should be described to you by the referring physician.

It is understood that the amount paid for x-rays, is for examination only and the X-ray originals remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Do you have any questions regarding the above authorization statement? (___) No (___) Yes, Please explain:_____

Parent/Guardian Name (please print) _____Parent/Guardian Signature_____

Date: _____ Doctors Initials_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

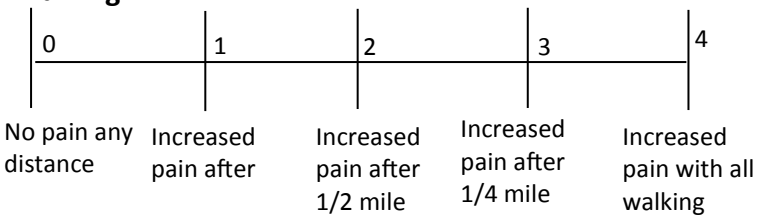
I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

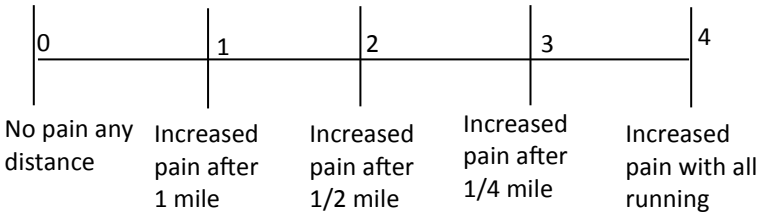
Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your child's condition right now**. Mark all that apply.

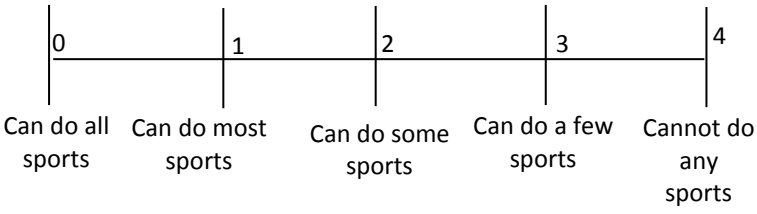
Walking



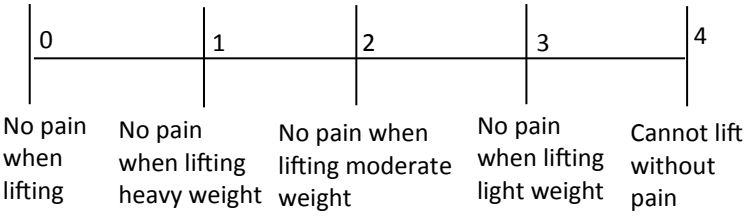
Running



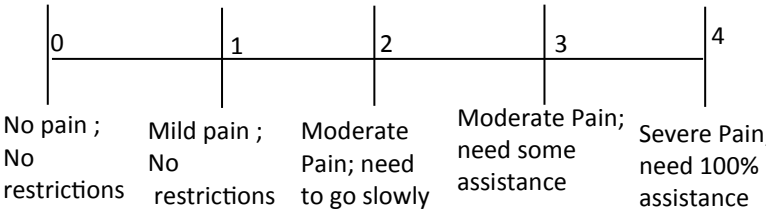
Recreation



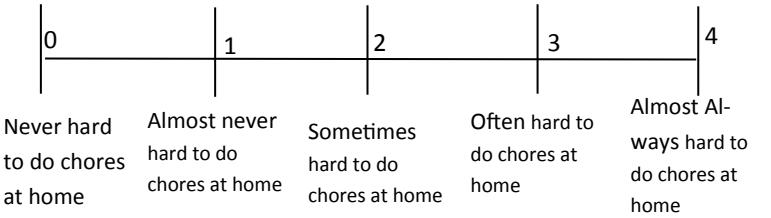
Lifting



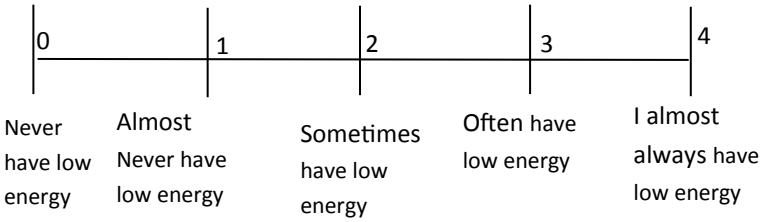
Personal Care (washing, dressing, etc.)



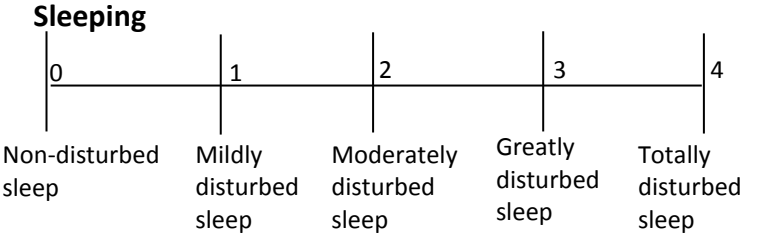
Chores/Work



Energy

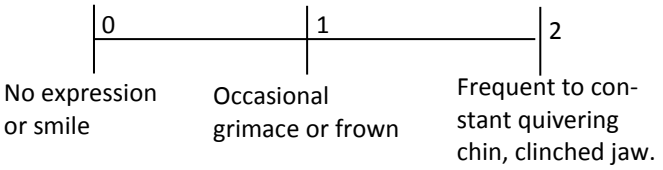


Sleeping

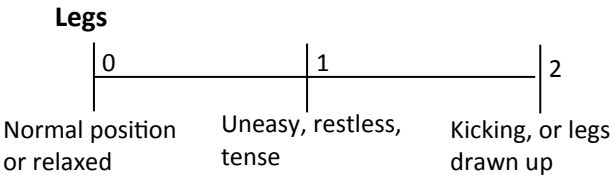


INFANTS ONLY

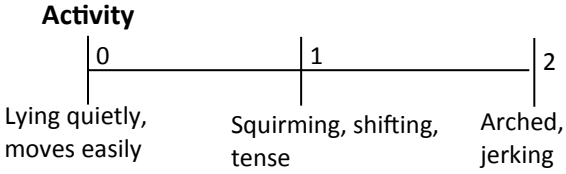
Face



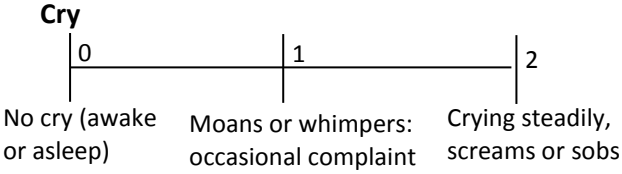
Legs



Activity



Cry



Consolability