CONFIDENTIAL PATIENT INFORMATION: Pediatric (10 Years & Younger)

(Please Print Clearly) Date: _____

Name of Child _____ Phone Number_____

D.O.B. _____ Age_____. Sex: M F

Home Address_____City _____State _____Zip_____

Name Parent/Guardian filling out this form _____

PRENATAL HISTORY

What supplements did mom take while pregnant? _____

Diagnosed with gestational diabetes? Yes No

BIRTH HISTORY

Any Ultrasounds taken? Yes No How many? _____ Why? _____

Where was child born?: Hospital Birthing Center at Home

What was your child's birth like? _____

How long was your entire labor? _____ How long did you actually push? _____

Were you **induced**? Yes No **Nerve block** (Epidural)? Yes No **C-section**? Yes No

Any Medical **Drugs**/Over the Counter drugs given? Yes No **Drug**s for pain? Yes No

Was there any pulling on the head? Yes No Forceps or vacuum extraction used? Yes No

Jaundice at birth? _____ APGAR score @ birth? _____

DEVELOPMENTAL HEALTH HISTORY

When did baby first turn over? _____crawl? _____walk? _____ talk? _____

Breastfed? Yes No How long ? _____ Ever have **cow's milk**? Yes No **Formula**? Yes No

1st Introduction to **solid food** (when?) _____ What type? _____

TRAUMA HISTORY

Has your child ever been vaccinated? Yes No Ever had a reaction to vaccine? Yes No

If so, **what type?**

Fever	Dizziness	Rash	Runny Nose	Ear Infection	Lethargic
Decrease in verbal skills		Nonverbal	No eye contact/Withdrawn		Seizures
Redness/Swelling over injection site			Loss of consciousness		Irritable & easily agitated
Shallow breathing		Shrill, constant crying/whining			Diarrhea

When was your child's most recent fall? _____

Was any care given? _____ Was s/he checked by a chiropractor? _____

Ever fallen off the bed? Describe : _____

Previous fall? _____ Any care given? _____

What sports or recreational activities does your child take part in? _____

_____

What was his/her most recent stress, strain, or injury while doing these activities? _____

_____

Any care given? _____

CURRENT HEALTH CONCERNS

Please list any current health concerns _____

_____

If any, how long? _____

Subluxated vertebrae can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.

Are there any other conditions s/he is or was experiencing? _____

How long? _____

Depending on the type and degree of the subluxated vertebrae, the nerve pressure can be constant or occasional. How often does s/he have this condition? _____

Any medications? _____

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 for your records within 30 days of 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:**

_____ _____