Pediatric Patient Information Form

Today's Date:	Date of Birth:		
Name:	☐ Male ☐ Female	Age:	Name of Parents/Guardians:

Address:	City:	State:	Zip:

Email:	Cell Phone:	Home Phone:

INSURANCE	
Who is responsible for this bill?:	Relationship to patient:
Insurance Company:	I.D. #:
Do you have any additional Insurance?: ☐ Yes ☐ No	
If Yes, name of Insurance:	I.D.#
Pediatrician:	

CURRENT HEALTH CONDITION	
	Chief Complaint: (why are you here today?)
Please circle areas of discomfort	

Body Area Involved:	☐ Cervical (neck)		☐ Upper Extremity (arms, wrist, hands)			
	☐ Spine (mid-back), ribs, pelvis (low-back)		☐ Lower Expremity (legs, feet, toes)			
Condition:	☐ New	☐ Recurring	☐ Exacerbation	☐ Chronic		
Mechanism of Onset:	☐ Auto	☐ Fall	☐ Sports Injury	☐ Unknown	☐ Slip or Fall	☐ Other
	☐ Slept Wrong		☐ No injury			
Symptoms:	☐ Pain		☐ Stiffness			
	☐ Numbness		☐ Weakness			
Location:	☐ Left		☐ Bilateral			
	☐ Right					
Quality:	☐ Burning	☐ Sharp	☐ Dull/Aching	☐ Stabbing	☐ Tightness	☐ Radiating
	☐ Shooring	☐ Diffuse	☐ Localized	☐ Throbbing	☐ Tingling	☐ Other

On a scale of 0-10, (10 being the worst) Rate your symptoms (Resting):	0	1	2	3	4	5	6	7	8	9	10
On a scale of 0-10, (10 being the worst) Rate your symptoms (with Activity):	0	1	2	3	4	5	6	7	8	9	10

Duration, Symptom(s) Started:

Symptom(s) Worsened:

Symptom(s) Last Occurred:

Injury Occurred:

Accident Occurred:

Timing Worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ W/Activity ☐ Constant ☐ Intermittent

Associated Signs & Symptoms: ☐ Blurred Vision ☐ Headaches ☐ Nausea ☐ Sleep Disturbance ☐ Vision Problems ☐ Irritability ☐ Mood Swings ☐ Stiffness ☐ Depression ☐ Radiating ☐ Localized Tingling ☐ Ringing in Ears ☐ Dizziness

Quality of Headaches: ☐ Dull ☐ Sharp ☐ Aura ☐ Stabbing ☐ Throbbing ☐ No Aura

☐ Radiation: ☐ Left ☐ Right ☐ Bilateral

☐ Weakness: ☐ Left ☐ Right ☐ Bilateral

Other Assoc. Signs & Symptoms: ☐ Aches ☐ Fever ☐ Numbness ☐ Runny Nose ☐ Tingling ☐ Cold Limb ☐ Heartburn ☐ Pale Bluish Skin ☐ Stiffness ☐ Vomiting ☐ Dizziness ☐ Muscle Spasm ☐ Panic ☐ Sweating ☐ Weakness ☐ Fatigue ☐ Nausea ☐ Pins & Needles ☐ Swelling

Modifying Factors – Symptoms Better With: ☐ Activity ☐ Cold ☐ Massage ☐ OTC Meds ☐ Rest ☐ Sitting ☐ Twisting ☐ Bending ☐ Heat ☐ Movement ☐ RX Meds ☐ Stretching ☐ Standing ☐ Walking ☐ Nothing

Since condition began, has anything permanently helped you? ☐ Yes ☐ No

Has anything that you have done done, thus far, fixed your problem? ☐ Yes ☐ No

HEALTH HISTORY

Check any of the following conditions your child has suffered during the past 6 months:

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

Does the patient have any other health concerns?:

Prenatal History:

Complications during pregnancy? ☐ Yes ☐ No If Yes:
Complications during delivery? ☐ Yes ☐ No If Yes:
Cigarette/Alchol use during pregnancy? ☐ Yes ☐ No If Yes:
Birth Intervention: ☐ Yes ☐ No If Yes:

Is your child involved in any contact sports? ☐ Yes ☐ No If Yes:

According to the National Safety Council, approximately 50% of children fall headfirst from a high place during the first year of life (i.e. bed, changing table, down stairs, etc.). Was this the case with your child?

☐ Yes ☐ No

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITES											
Activity (Check applicable column)	0 No Effect	1	2	3	4	5	6	7	8	9	10 Unable to do
Bending:											
Change Pos. -Sit-Stand:											
Climb Stairs:											
Extended Computer Use:											
Eating:											
Exercise:											
Kneeling:											
Lifting:											
Reading (Concentration):											
Self Care:											
Self Care (Bathing):											
Self Care (Dressing):											
Sleep:											
Sitting:											
Sports:											
Standing:											
Walking:											

PREVIOUS TREATMENT			
Previous Chiropractic Care:	☐ Yes, if yes, who? (name) ☐ No		
Have you seen other Doctors for this Condition?	☐Yes, if yes, who? (name) ☐No	Location of Office:	Type of Treatment:

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Precision Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Precision Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my child’s care or treatment, any fees for professional services rendered to me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my child’s condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

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 by this office.

Guardian or spouse’s signature of authorizing care: (signature indicates consent to treat)		Date:
Patient (print name):	Patient’s Signature:	Date: