

Pediatric Patient Information Form

Today's Date:	Date of Birth:		
Name:	<input type="checkbox"/> Male <input type="checkbox"/> 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?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, name of Insurance:	I.D.#
Pediatrician:	

CURRENT HEALTH CONDITION

	<p>Chief Complaint: (why are you here today?)</p> <hr/>
--	---

Please circle areas of discomfort

Body Area Involved:	<input type="checkbox"/> Cervical (neck) <input type="checkbox"/> Spine (mid-back), ribs, pelvis (low-back)	<input type="checkbox"/> Upper Extremity (arms, wrist, hands) <input type="checkbox"/> Lower Extremity (legs, feet, toes)
Condition:	<input type="checkbox"/> New <input type="checkbox"/> Recurring <input type="checkbox"/> Exacerbation <input type="checkbox"/> Chronic	
Mechanism of Onset:	<input type="checkbox"/> Auto <input type="checkbox"/> Fall <input type="checkbox"/> Sports Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Slip or Fall <input type="checkbox"/> Other <input type="checkbox"/> Slept Wrong <input type="checkbox"/> No injury	
Symptoms:	<input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness	
Location:	<input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Right	
Quality:	<input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Dul/Aching <input type="checkbox"/> Stabbing <input type="checkbox"/> Tightness <input type="checkbox"/> Radiating <input type="checkbox"/> Shooring <input type="checkbox"/> Diffuse <input type="checkbox"/> Localized <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> 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: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night <input type="checkbox"/> W/Activity <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent															
Associated Signs & Symptoms:	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nausea	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Irritability	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Depression	<input type="checkbox"/> Radiating	<input type="checkbox"/> Localized Tingling	<input type="checkbox"/> Ringing in Ears			
	<input type="checkbox"/> Dizziness														
Quality of Headaches:	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aura	<input type="checkbox"/> Radiation:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Weakness:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral				
	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Throbbing	<input type="checkbox"/> No Aura												
Other Assoc. Signs & Symptoms:	<input type="checkbox"/> Aches	<input type="checkbox"/> Fever	<input type="checkbox"/> Numbness	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Tingling	<input type="checkbox"/> Cold Limb	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Pale Bluish Skin	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Spasm	<input type="checkbox"/> Panic	<input type="checkbox"/> Sweating	<input type="checkbox"/> Weakness
	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Swelling											
Modifying Factors – Symptoms Better With:	<input type="checkbox"/> Activity	<input type="checkbox"/> Cold	<input type="checkbox"/> Massage	<input type="checkbox"/> OTC Meds	<input type="checkbox"/> Rest	<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Bending	<input type="checkbox"/> Heat	<input type="checkbox"/> Movement	<input type="checkbox"/> RX Meds	<input type="checkbox"/> Stretching	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	
	<input type="checkbox"/> Nothing														
Since condition began, has anything permanently helped you?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Has anything that you have done done, thus far, fixed your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
HEALTH HISTORY															
Check any of the following conditions your child has suffered during the past 6 months:															
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizure	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> ADHD	<input type="checkbox"/> Colic	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Other	
Does the patient have any other health concerns?:															
Prenatal History:															
Complications during pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:												
Complications during delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:												
Cigarette/Alcohol use during pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:												
Birth Intervention:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:												
Is your child involved in any contact sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?															
<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes, if yes, who? (name)		
	<input type="checkbox"/> No		
Have you seen other Doctors for this Condition?	<input type="checkbox"/> Yes, if yes, who? (name)	Location of Office:	Type of Treatment:
	<input type="checkbox"/> No		

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: