

Pediatric Health History Form

Child's Name: _____ Date: _____ Patient Number: _____

Parent Names: _____ Sibling's Names & Ages: _____

Child's Age: _____ Birth date: _____ (mm/dd/yyyy) Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Other Number: _____

Email address: _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Please check the purpose for your child's visit:

- crisis management early detection of problems prevention
 wellness maximizing normal growth and development other: _____

Present Health Concerns

Please identify the condition(s) that brought your child to our office and on a scale of 1 to 10 with 10 being the worst possible pain and 0 being no pain, rate your child's conditions:

Major _____ 0-1-2-3-4-5-6-7-8-9-10
Minor _____ 0-1-2-3-4-5-6-7-8-9-10

When did this problem begin? _____

Is this problem: occasional frequent constant intermittent

Does problem radiate? Yes No If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No

If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

Has your child ever received chiropractic care? Yes No

If yes, who is your child's previous Doctor of Chiropractic? _____

The date of last visit: _____

The reason for the last visit: _____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent test done (list date beside): Bloodwork _____ Urine _____ X-rays _____ Other: explain

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Often seemingly unrelated symptoms can manifest as other health concerns... Please mark if your child has had any of the following

- | | | |
|------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chest pressure | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> breast pain | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> irritability | <input type="checkbox"/> frequent colds | <input type="checkbox"/> dental problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> fevers |
| <input type="checkbox"/> depression | <input type="checkbox"/> sore throats | <input type="checkbox"/> heart palpitations |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> numbness in feet |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> bronchitis | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> poor coordination | <input type="checkbox"/> pneumonia | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> constipation | <input type="checkbox"/> radiating pain |
| <input type="checkbox"/> light sensitivity | <input type="checkbox"/> diarrhea | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> urinary problems | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> reduced mobility | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> stiffness |

Birth History

What was the child's gestational age at birth? ____ weeks.

Birth weight _____ lbs. _____ oz

Birth length _____ inches

Was your child's birth: at home in a birthing center hospital other

Was the birth considered: medical midwife

Duration of birth: _____ hours

Was child born: cephalic (headfirst) breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labor: spontaneous induced Were medications or epidurals given to the mother during birth? Yes No

APGAR score: at Birth ____/10 After 5 minutes ____/10

Is there anything else we need to know about the birth Yes No

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Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child:	Respond to sound _____	Follow an object _____
	Hold up head _____	Vocalize _____
	Sit alone _____	Teethe _____
	Crawl _____	Walk _____

Does your child sleep: front back side

Do you consider the child's sleeping pattern normal? Yes No How many hours per day? _____

If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant?

- bruising
- odd shaped head
- stuck in birth canal
- fast or excessively long birth
- respiratory depression
- cord around neck

Any falls from couches, beds, change tables, etc.? Yes No

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No

If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No Is it heavy or light?

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Chemical Stressors

Was this child breast-fed? Yes No If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No

Type: _____

Do you use non-toxic products in your home? _____

Is your child on or have taken any medications? _____

Is your child circumcised? Yes No

Has your child received any vaccinations? Yes No

Please indicate which vaccine your child has received and when.

Birth - Hep B Yes No Vitamin K Yes No

1-2 Months - Hep B Yes No

2 Months - DtaP Yes No Hib Yes No IPV Yes No PCV Yes No RV Yes No

4 Months - DtaP Yes No Hib Yes No IPV Yes No PCV Yes No RV Yes No

6 Months - DtaP Yes No Hib Yes No PCV Yes No RV Yes No Influenza Yes No

6-18 Months - HepB Yes No IPV Yes No Influenza Yes No

12-15 Months - Hib Yes No MMR Yes No PCV Yes No Chickenpox Yes No

12-23 Months - HepA Yes No Influenza Yes No

15-18 Months - Dtap Yes No Influenza Yes No

4-6 Years - Dtap Yes No MMR Yes No IPV Yes No Varicella Yes No Influenza Yes No

During the mother's pregnancy:

Did the mother smoke? Yes No How much? _____

Drink alcohol? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, describe: _____

Any supplements taken during pregnancy? Yes No If yes, describe: _____

Any drugs taken during pregnancy? Yes No _____

Any ultrasounds? Yes No How many: _____

Reasons for being done: _____

Any invasive procedures during pregnancy (i.e. amniocentesis, Chorionic villi sampling, etc.)? Yes No

If yes, please explain _____

Any pets at home? Yes No _____

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

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Is the diet organic? Yes No

Do you use 'green products' in your home for cleaning? Yes No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? Never On weekends A few times per week Daily Nearly each meal On special occasions

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No

Psychosocial Stressors

Any difficulties with lactation? Yes No _____

Any problems with bonding? Yes No _____

Any behavioral problems? Yes No _____

Any inattention? Yes No _____

Any hyperactivity or restlessness? Yes No _____

Any compulsiveness? Yes No _____

Any difficulties at daycare or school? Yes No _____

Any challenges with learning deficiencies? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Any prolonged temper tantrums or separation anxiety? Yes No _____

Is the child in day care Yes No _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work Yes No _____?

Is the child home schooled? Yes No _____ by Whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

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Often seemingly unrelated symptoms can manifest as other health concerns... Please mark if your child has had any of the following

- | | | |
|--------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> poor hand-eye coordination | <input type="checkbox"/> difficulty catching a ball | <input type="checkbox"/> poor balance |
| <input type="checkbox"/> easily distracted | <input type="checkbox"/> messy handwriting | <input type="checkbox"/> skipping parts of a line when reading |
| <input type="checkbox"/> difficulty copying from a blackboard | <input type="checkbox"/> poor pencil grip | <input type="checkbox"/> poor fine motor skills |
| <input type="checkbox"/> messy handwriting; poor pencil grip | <input type="checkbox"/> poor spelling | <input type="checkbox"/> stick out tongue when writing |
| <input type="checkbox"/> slouching at the desk or computer | <input type="checkbox"/> difficulty to process ideas | <input type="checkbox"/> poor verbal expression & articulation |
| <input type="checkbox"/> over sensitive and reactive to sensory stimulus | <input type="checkbox"/> poor impulse control and highly reactive | <input type="checkbox"/> easily distracted and hyperactive |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> social and emotional immaturity | <input type="checkbox"/> anxiety and unable to adapt well to change | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> motion sickness | <input type="checkbox"/> poor balance and coordination | <input type="checkbox"/> thumb sucking |
| <input type="checkbox"/> chewing on hair, sucking on sleeves | <input type="checkbox"/> difficulty with speech and pronunciation | <input type="checkbox"/> poor posture and coordination |
| <input type="checkbox"/> lack of ability to sit still | <input type="checkbox"/> lack of attention and concentration | <input type="checkbox"/> clumsiness |
| <input type="checkbox"/> bedwetting and poor bladder control | <input type="checkbox"/> late crawler or skip crawling | <input type="checkbox"/> poor muscle tone |
| <input type="checkbox"/> tendency to slump while sitting | <input type="checkbox"/> inability to sit still | <input type="checkbox"/> lack of concentration |
| <input type="checkbox"/> poor organizational and planning skills | <input type="checkbox"/> difficulty sitting upright | <input type="checkbox"/> poor muscle tone |
| <input type="checkbox"/> tendency to walk on toes | <input type="checkbox"/> motion sickness | <input type="checkbox"/> poor balance |
| <input type="checkbox"/> poor posture | <input type="checkbox"/> short term memory difficulty | <input type="checkbox"/> difficulty swimming the breaststroke |
| <input type="checkbox"/> weak upper body | | |

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

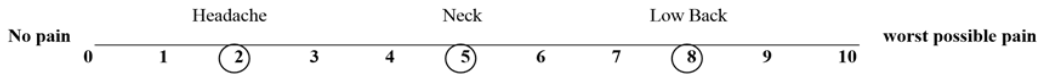
Date _____

Please read carefully:

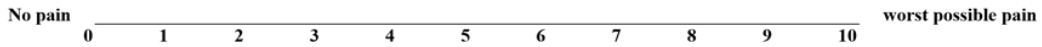
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



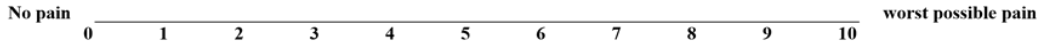
1 – What is your pain RIGHT NOW?



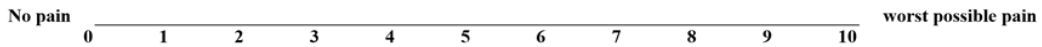
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

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Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

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HIPPA Law #101-191 Consent Form

The information you provide us is kept in the strictest of confidence.

While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health information.

1. It may be necessary to use or disclose your private health information to another health care provider or hospital, if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health issue.

2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.

3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purpose including:

- a. appointment reminders at home
- b. appointment reminders at work
- c. leaving messages on a voicemail or answering machine
- d. testimonials of your improvement in written or verbal form
- e. sending you marketing materials
- f. information about alternative treatments
- g. other health related information that may be of interest to you
- h. "Thank you" correspondence

Patients' Rights Under HIPPA Law #101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies, or organizations under the following circumstances:

- a. all request must be in writing
- b. by law we are not required to agree with your restrictions however, if we agree with your restrictions, the restriction is binding on us.

2. You have the right to REVOKE your authorization under certain conditions.

- a. it must be in writing
- b. the request will not be honored if we have already released your private health information before we received your request to revoke the authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance may have the right to our private health information, should they decide to contest any of your claims. Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone that has access to the remainder of other information and may no longer be protected by the federal privacy rules.
- c. If you do not give us authorization, it will not affect the treatment we provide to our patients or the methods we use to obtain reimbursement for services rendered to you.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records. This notice is effective on the date below and will expire seven years after the date upon which the record was created.

Print your name

Authorized Signature

Signature

Date

- Note: We have a more detailed notice of "Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by posting of the changes in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

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Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully

In order for Dr. DeLong to make a determination on the suitability of my child's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. DeLong, or any party authorized to do so by that person.

I have had the opportunity to discuss with Dr. DeLong, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: _____

Date: _____

Signature: _____

Witness: _____

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ / ____ / ____



Witness Initials

Patient or Authorized Person's Signature

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ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

OUR OFFICE POLICIES

Welcome to **DeLong Family Chiropractic!**

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **DeLong Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body’s innate wisdom. The doctors **use a myriad** of techniques to accomplish this goal, including but not limited to **Palmer Package**. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through **two** distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining

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the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Name

DOB

HR#

Patient signature

Date

Witness

Date