

Date: ___/___/_____ Time: _____

Chiropractic Pediatric Case History Form (Newborn-16 years of age)

Welcome to La Vista Chiropractic & Wellness Center! We look forward to working with your family to achieve optimum health. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay even though there is no pain felt. A dentist checks for these "painless" cavities just as a chiropractor checks for spinal misalignment to maintain spinal health. Chiropractic does not cure any disease or treat symptoms alone. Rather, our chiropractic analysis will focus on removing nervous system interference, caused by physical, chemical, and/or emotional stressors, allowing the child's body to properly express health. To help us serve you better, please complete the following:

Personal Information

Name: _____ Gender (circle): M F
(Legal Last) Middle Initial (Legal First)

Address: _____ City/State: _____ Zip Code: _____

Age: Years _____ Months _____ Date of Birth: (mm/dd/yr) _____ Social Security #: _____

Name of Father: _____ Name of Mother: _____

Home Phone Number: _____ Home Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Work Phone Number: _____

Legal Guardian (if other than parent): _____

Who is responsible for your bill (please check) Parent(s) (Guardian) Personal Injury

Health Insurance Company Name (if applicable): _____

Insured's Name: _____ Relationship to Patient: _____

How did you hear about our office? Is there someone that we may thank for referring you to our office?

Birth History

Delivery Method: (please check all that apply)

Vaginal Forceps Vacuum Extraction Caesarean Section Medication during pregnancy or delivery

What position was the child in during delivery? _____

Was the mother under chiropractic care during the pregnancy? No Yes

Any complications during the pregnancy or with the delivery? No Yes, explain: _____

Any known congenital anomalies / defects? No Yes, please explain: _____

Past Health Information

Family Doctor Name/ Pediatrician

Dr.'s Name _____ Clinic Name/Location _____ Date of Last Visit _____

Has your child had previous chiropractic care? No Yes (please provide info below)

Dr.'s Name _____ Clinic Name/Location _____ Date of Last Visit _____

Please describe the reason for previous care: _____

Has your child ever been in an auto accident? No Yes (please provide info below)

Approximate Date: _____ Describe Incident: _____

Has your child had any other major injuries, falls, head injuries, or accidents? No Yes (please explain)

Approximate Date: _____ Describe Incident: _____

Approximate Date: _____ Describe Incident: _____

Has your child had any broken bones or dislocations? No Yes, which: _____

Is your child involved or ever been involved in any high impact or contact sports (wrestling, football, soccer, gymnastics, baseball, martial arts, etc.)? No Yes, please list: _____

Has your child had any surgical operations or been hospitalized? No Yes (please provide info below)

Approximate Date: _____ Describe: _____

Please indicate if any of the following conditions are known in your family:

Cancer (Relationship to child: _____) Heart Disease (Relationship to child: _____)

Diabetes (Relationship to child: _____) Headaches (Relationship to child: _____)

Other: _____ (Relationship to child: _____)

Vital Health Information

Current Weight: _____ Current Height or Length: _____

Do you notice any developmental delays with your child? () No () Yes, explain: _____

Current Habits

Please check any of the below habits that your child has:

- () Junk Food () Healthy Foods () Pop/Soda/High Sugar Fruit Drink Intake
 () High Level of Activity/Exercise () Low Level of Activity/Exercise
 () Stress () Lack of Focus () Difficulty in School
 () Smoking () Drinking Alcohol () Excessive Television/Computer/Video Game use

Current Health Challenge

Reason why your child is here: () Wellness Spinal Check () Specific Condition(s)

Is this condition due to an accident or specific event/incident? () No () Yes, please explain: _____

Do you feel your child's present diet, environment, and/or physical activity level related to his/her present health challenge? () No () Yes, please explain: _____

Doctor's visit or Hospitalization for the current condition? () No () Yes, please fill out below:

Date: _____ Where: _____ Treatment Given: _____

What other treatment options have you attempted to improve the condition? _____

How long has this condition been bothering your child?

() 1 week () 2-7 weeks () 2-4 months () greater than 4 months

How often does this condition bother your child? (please check one)

() Daily: Number per Day ____ () Weekly: Number per Week ____ () Monthly: Number per Month ____

Has your child ever had similar conditions in the past? () No () Yes, When: _____

This condition is (check one): () Getting worse () Staying the same () Slowly improving () Rapidly improving

Do any particular activities or movements (standing, sitting, lying down, bending, twisting, lifting, walking, etc.) aggravate the condition? _____

Is this condition interfering with: School () Sleep () Concentration () Daily Routine ()

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health: _____

Medication/ Supplementation

Please provide any Nutritional Supplement, Over-the-Counter Medication, or Prescription Medication taken by the child in the last year. Please include vaccinations and antibiotics.

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

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 weight within 6 months
- Jaw/TMJ Problems
- Ruptures/hernias

Serious Illnesses/Diseases

- 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: ___)

Emotional/ Mental

- Nervousness/Anxiety
- Unexplained Fatigue
- Depression
- Irritability/Mood Swings
- Tension/Stress
- Behavioral Issues
- Hyperactivity

Integumentary System

- Skin Problems
- Rashes
- Hives
- Skin Sensitivity
- Easy Bruising

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
- Allergies
- Recurrent Ear Infections
- Tooth Abscess
- Difficulty Hearing

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

Gastro-Intestinal System

- Gall Bladder Problems
- Digestive Problems
- Stomach Upset
- Heartburn/Reflux
- Diarrhea/Constipation/Gas
- Poor appetite
- Food allergies or intolerances

Genito-Urinary System

- Recurring Infections
- Difficulty Urinating
- Bed Wetting

Cardiovascular System

- Diabetes Type I or II
- High Blood Pressure
- Chest Pain
- Heart Problems
- Anemia

Respiratory System

- Asthma
- Chronic Cough/Cold
- Difficulty Breathing
- Pain w/Cough / Sneeze
- Shortness of Breath
- Lung Problems
- Recurring Infections
- Sinus 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

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

Signature of guardian verifying patient is NOT pregnant:

Patient Informed Consent, Financial Policy, and Authorization for Care of Minor:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that La Vista 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 La Vista Chiropractic will be credited to my account. I clearly understand that all services rendered to 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 La Vista 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 child, 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.

Patient Consent for Use and Disclosure of Protected Health Information:

With my consent La Vista Chiropractic & Wellness Center, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to La Vista Chiropractic’s Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing the consent. La Vista Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to La Vista Chiropractic & Wellness Center, P.C., Attn: Privacy Officer at 7202 Giles Road, Suite 7, La Vista, NE 68128.

With my consent, La Vista Chiropractic may call my home, or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care. Also, with my consent, La Vista Chiropractic may send mail to my home involving the above items named in this paragraph pursuant to my clinical care and/or insurance status as long as they are marked personal and confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by its agreement. By signing this form, I am consenting to the use by La Vista Chiropractic of my protected health information to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, the doctors at La Vista Chiropractic & Wellness Center, P.C. may decline to provide treatment to me.

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_____