Ghent Chiropractic

Chiropractic Case History/ Pediatric Patient Information

Date _____ Patient # _____

Doctor _____

Child's Name: _____

Mother's Name: _____Father's Name: _____

Address _____City _____State _____ Zip _____

Home Phone: _____Mother's Work Phone: _____Father's Work Phone: _____

Birth Date: _____ Age: _____ Birth Weight: _____ Current Weight: _____

Sex: _____ Number of Siblings: _____ Birth Length: _____ Current Length: _____

Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Home _____ Birthing Center _____ Hospital _____

Problems during Pregnancy: _____

_____

Problems during Labor / Delivery: _____

_____

Apgar Scores: _____Was there presence at birth of: _____ Jaundice (yellow) _____ Cyanosis (blue)

Congenital Anomalies/ Defects: _____

Infant Feeding: Breast_____ Bottle_____ Formula _____

Number of hours sleep per night: _____ Quality of sleep: Good _____ Fair _____ Poor _____

Obstetrician / Midwife: _____ Where: _____

Pediatrician / Family MD: _____ Where: _____

Date of last visit to MD: _____ Purpose: _____

Immunization History: _____

Purpose of this appointment _____

Has your child ever been treated on an emergency basis? _____

Describe: _____

How were you referred to our office? _____

Would you like the findings of our examination sent to your medical doctor? Yes_____ No_____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: _____

_____

What surgeries have you had? (Include dates)

_____

Serious illnesses (include dates) _____

_____

Has a physician treated you for any health condition in the last year? ☐ Yes ☐ No

If yes, describe: _____

_____

What medications or drugs are you taking? _____

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem? _____
   How did it originally occur? _____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____

7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____
   _____

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this Form either in the past or the present? Yes ____ No ____. If yes, please explain _____
    _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____

12. Remarks: _____

_____

_____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____

Please check any and all insurance coverage that may be applicable in this case**.**

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid

☐ Medicare ☐ Auto Accident ☐ Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 1.5%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____