Pediatric Health History Form

Patient Name: _____
Name of Parents/ Guardians_____
Address_____City_____State_____ Zip_____
Home Phone _____ Work Phone_____ Cell _____
Email Address_____
Date of Birth _____ Sex M / F Weight_____ Height _____Number of siblings___
Who referred you to us? _____
Reason for seeking care:_____
Other Doctors seen for this conditions Y/ N Specialty:_____
Prior treatment and outcome:_____
Other Health Problems:_____
Surgery:_____

Symptons: Please check any current or past problems your child has on the list below:

___Dizziness	___Allergies	___Diarrhea	___Broken Bones
___ADHD	___Runny Nose	___Poor Appetite	___Sprains/Strains
___Backaches	___Itchy Eyes	___Hyperactivity	___Hernias
___Heart Condition	___Rashes	___Rashes	___Neck pain
___Chronic Earaches	___Unusal Moles	___Poor Memory	___Arm/Elbow pain
___Diabetes	___Neuritis	___Insomnia	___Leg/hip pain
___Tuberculosis	___Digestive problem	___Nightmares	___Knee/Foot Pain
___Hypertension	___Sinus Trouble	___Bed Wetting	___Growing Pains
___Fever/Chills	___Cough/Wheeze	___Pain Urinating	___Joint Pain
___Frequent Colds	___Chest pain	___Convulsions	___Paralysis
___Arthritis	___Constipation	___Muscle Pain	___Blood Disorders
___Headaches	___Anemia	____Fainting	___Stomach Aches
___Asthma	___Rheumatic Fever	____Scoliosis	___Other
___Tumors Benign/malignant			

Health History:

Name of Pediatrician:_____Date of Last Visit:_____
Reason for visit:_____
Medications and conditions being treated:
_____
Has your child ever taken antibiotics Y/N condition treated: _____
Has your child been injured participating in contact sports Y/N
If yes describe the injury:_____
Has your child ever been involved in a car accident? Y/N Date of injury:_____
Has your child ever fallen head first from (Changing table, Bed, Stairs..) Y/N
Other Traumas_____
Menarche Y/N age: _____

Prenatal History:

Location of Birth: _____
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy Y?N Number: _____
Medications during pregnancy/ delivery: Y/N List: _____
Cigarette/Alcohol during pregnancy Y/N
Birth interventions: Forceps, Vacuum, Caesarian, briefly explain reason for intervention:
_____
Complication's during delivery: _____
Genetic disorders/ disabilities Y/N_____
Birth Weight_____Birth length_____APCAR scores 1min_____ 5min_____

Feeding History:

Breast fed Y/N How long?_____ Formula fed Y/N How Long?_____
Type:_____ Introduced to solids at _____months Cow's mik at ____months
Food/ juice allergies or intolerances Y/N List_____

Developmental History:

Sleep (hrs per night) _____ Naps (number and Lengths) _____ Problems Sleeping Y/N
At what age was your child able to: Crawl___ Sit alone_____ Stand alone_____
Walk alone_____ Say Words ____

Childhood Illnesses:

Check all that apply
____Chicken pox, Age ___ ___Mumps, Age____ ____Rubella, Age __
____Whooping Cough, Age ____ ___Measles, Age_____Meningitis, Age__
____Tuberculosis, Age___ ____Other _____

Vaccination History
o HBV/Hep (Hepatitis B) Age ____ o MMR (Measles, Mumps, Rubella) Age___
o DPT (Diptheria, Tetanus, Pertussis) Age____o Varicella (chicken Pox) Age____
oHbCV/ Hib (h. influenzae type b conjugate) Age___ o PCV (pneumoccocal) Age____
oOPV (oral polio vaccine) or IPV (inactivated Poliovirus) Age____
Adverse Reactions to any Vaccine Y/N List: _____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed_____ Date_____

Informed Consent & Office Policies

Our commitment here at the Los Gatos Chiropractic and Wellness Center is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interest it may be necessary to share information with other Health care Providers or Associates for the purpose of ordering laboratory analysis, payment, scheduling of your appointment or in the instance of a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released with the written authorization of the individual, as provided for by law.

Please be aware Health and Safety Code section 109250 et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation or cure of cancer. If you have been diagnosed with cancer we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit cards, master card, visa, cash and check are acceptable forms of payment.

Please be advised that if you cannot keep your scheduled procedure or appointment for any reason, we request that you cancel the appointment with at least 24 hours prior. Failure to cancel within that time frame or no showing for the appointment will be the cost of the appointment.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Los Gatos Chiropractic and Wellness Center, and Associates

I have read and understand this form.

Signed: _____

Print Name: _____Date:_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Parent/Guardian/Representative

_____
Signature of Patient's Parent/Guardian/Representative

As:_____
Relationship or Authority of Patient's Representative

_____
Date Signed

Name(s) of doctor(s) treating this patient:

Los Gatos Chiropractic and Wellness Center & Associates