PEDIATRIC HEALTH HISTORY FORM

Appointment Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Home phone (_____) _____	Home phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Maximize Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother (Check all that apply):

❑ Use any form of fertility treatment? If so, what treatment: _____
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol
❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ Hours _____
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malposition? ❑ No ❑ Yes _____

Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT	_____	❑ MMR	_____	❑ Other	_____
❑ Polio	_____	❑ Chicken Pox	_____		
❑ Hepatitis	_____	❑ Flu	_____		

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply	❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath
	❑ Massage Therapist	❑ Psychotherapist	❑ Energy Healer	❑ Other

Reason _____

Finances

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

First Visit Fees: Comprehensive Exam and X-Rays (Or Adjustment if Applicable): $130

PLEASE READ AND SIGN

1. I acknowledge that Nicholl Chiropractic Inc. has informed me that they are not in network with any insurance companies.
2. I have been informed that a copy Nicholl Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review.
3. I consent to receive communication from MC via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
4. I consent to my name and photo being posted on MC social media and or internet pages for testimonials. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
5. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Tim Nicholl permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name: (Printed)_____

Signature _____ Date: _____

Thank you for choosing Nicholl Chiropractic Inc.

We look forward to helping you.