

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 _____
Cell phone (_____) _____	Cellphone (_____) _____
Work 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

<input type="checkbox"/> School	<input type="checkbox"/> Exercise/Sports	<input type="checkbox"/> Walking
<input type="checkbox"/> Playing	<input type="checkbox"/> Sleep	<input type="checkbox"/> Attention/Focus
<input type="checkbox"/> Communication	<input type="checkbox"/> Eating	<input type="checkbox"/> 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:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> DPT _____ | <input type="checkbox"/> MMR _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Chicken Pox _____ | |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> 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
- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Medical Physician | <input type="checkbox"/> Naturopath | <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Psychotherapist | <input type="checkbox"/> Energy Healer | <input type="checkbox"/> 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, Report of Findings and 1st Adjustment: \$130

PLEASE READ AND SIGN

1. Insurance verification will take 12-24 hours; our insurance specialist will have all insurance details completed upon your second appointment. In the event coverage is present, the deposit of \$130 will be refunded, placed towards your deductible or co-pays.
2. Patients' with no insurance coverage are able to obtain discounts on care through Compliant Coupons; which office staff will enroll you in on your first appointment.
3. I consent to receive communication from the office 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 or photo being posted on Facebook and or private website. Yes No If I should withdraw my consent, I will notify the office in writing.
5. 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 me 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.
6. Cancellation Policy: Cancellation for scheduled appointments must be done within 24 hours or 1 business day. Appointments cancelled or unable to reschedule within the same day are subject a fee of \$65.
7. Dr. Tim participates actively with the ICPA research department for educating other doctors in the community. It is common for Exams and Treatments to be filmed for the sole purpose of training. If items are to be placed on-line or social media, notification and consent will take place.

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.